MATERNAL AND CHILD HEALTH BLOCK GRANTS

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BEFORE THE

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HEALTH AND THE ENVIRONMENT

OF THE

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MATERNAL AND CHILD HEALTH BLOCK GRANTS

MONDAY, MARCH 5, 1990

House of Representatives,
Committee on Energy and Commerce,
Subcommittee on Health and the Environment,
Chicago, IL.

The subcommittee met, pursuant to notice, at 9:30 a.m., in the Ceremonial Court Room, Dirksen Building, 219 South Dearborn, room 2525, Chicago, IL, Hon. Cardiss Collins, presiding (Hon. Henry A. Waxman, chairman).

Mrs. Collins. Good morning. This hearing of the House Subcommittee on Health and the Environment will come to order. This hearing has been convened because we face a health crisis in Chicago. Closures of hospitals and clinics, especially those that serve the poor, have reached alarming proportions. Our rate of infant mortality remains unconscionable. Access to basic health care for the poor is rapidly dwindling, and our network of hospitals providing trauma care is seriously compromised. In our efforts to get at the roots of this crisis, we are compelled to examine the policy of the State of Illinois with respect to two Federal programs intended by Congress to provide health care to the poor: Medicaid, and the Maternal and Child Health Block Grant Programs. Our task today is to begin an examination of whether these programs, under the direction of the State of Illinois, are meeting the health care needs of those who Congress intended to serve.

Medicaid is the primary Federal program to provide health care to the poor. It is administered by the States and supported with State moneys and Federal matching dollars. In 1987, Illinois ranked 50th among the States and the District of Columbia in the percentage of Medicaid costs reimbursed by the State according to the most recent available data from the Illinois Hospital Association. Illinois hospitals receive on average about 70 cents for each dollar spent to serve Medicaid patients, and many hospitals, including some in my district, receive much less. The Illinois Hospital Association estimates that the State of Illinois could receive an additional $167 million in Federal funds by fully funding Medicaid services provided by hospitals alone. Medicaid underfunding has been identified as a principle cause in many, if not most, hospital closings in recent years.

In reviewing Medicaid policy in Illinois, we must consider Illinois' system of reimbursement, the Illinois Competitive Access and Reimbursement Equity Program, better know as ICARE: we will

consider today whether that program is aptly named. ICARE is a system which contracts with hospitals for payment rates and volume of care. Because of a waiver secured by the Illinois Department of Public Aid, two critical components of Federal Medicaid law—one, freedom of choice of provider, and two, payment on a reasonable cost related basis—are not required in Illinois. The low rate of reimbursement to Illinois hospitals for care to the poor can be traced directly to the inception of the ICARE Program.

The providers hardest hit by ICARE are those who serve the largest number of Medicaid patients. In many neighborhoods, where Medicaid patients cannot receive physician services close to where they live, the local hospital is the only source of health care access. We must ask: Is the intent of Congress being carried out by ICARE if those providers who serve the poor experience the greatest financial burden under the program? We must commend Senate President Phil Rock and the members of the Illinois General Assembly for their action last year to increase funding for these "disproportionate share" providers, but such measures may offer only a short term solution to a larger systemic problem.

Last year, the Illinois Department of Public Aid was required to apply for a renewal of the Federal waivers which permit ICARE. As a requirement of the waiver, Illinois had to show evidence that the program "has no detrimental effects on access to services or quality of care." It is incomprehensible to me how Illinois could have successfully met this standard in light of what we know about the impact of the waivers on health care in Chicago. I strongly oppose the renewal of these waivers. When so many hospitals serving the poorer urban neighborhoods have closed since the inception of ICARE—among those are: Woodlawn, Englewood, St. Anne's, Mary Thompson, and Provident, to name just a few—common sense dictates that we have a problem.

A study by Peat Marwick & Co. was commissioned by the Illinois Department of Public Aid and supported their contention that ICARE has not compromised health care access and quality. But, last year a group of Chicago area hospitals commissioned the firm of Ernst & Whinney to analyze the available data, and they arrived at quite different conclusions. Focusing on hospitals in the Chicago westside market, in my own congressional district, the study arrived at several distressing conclusions: First, the Illinois Medicaid payment system is undermining the viability of these disproportionate share providers, and if left unchanged, may lead to closure of most or all of these institutions; second, the closure of even a portion of these hospitals will pose significant access problems for medically indigent study area residents; third, the average reimbursement rate for the hospitals bordering the westside study area was $532 per day, compared to the average for hospitals within the study area of a mere $350 per day; and fourth, the hospitals in the study area, on balance, are being managed with reasonable efficiency when compared to averages for community hospitals in the United States.

The ICARE system may also bear some responsibility for the recent crisis in our city's trauma network. Each hospital contracting with the State of Illinois for Medicaid services is limited to the number of Medicaid patients for which they will be paid. The evi-

dence suggests that these limitations on how many patients a hospital can serve are particularly problematic in specialty care areas such as trauma and burn care. When the allotment of specialty and general care days allowed by the Illinois Department of Public Aid are exhausted, as they often are, hospitals in the trauma network must provide free care to Medicaid patients. The resulting financial burden on trauma network hospitals is a significant part of the problem we now face.

While containment of hospital costs is a necessary and laudatory goal, we must be certain that we are not saving money at the expense of Illinois' citizens least able to fend for themselves.

Another Federal program administered by the State of Illinois, through the Department of Public Health, is the Maternal and Child Health Block Grant Program. I have long been concerned about Federal funds earmarked to combat infant mortality are targeted to areas where they are most needed. However, it has come to my attention that, at least in some cases, this has not been the case. During the 5 year period from 1986 to 1990, the Federal allocation to the State of Illinois under the Maternal and Child Health Care Block Grant has increased by approximately 23 percent according to the Illinois Department of Public Health. However, I am informed by the Chicago Department of Health that they have experienced an increase of around 2 percent.

Today, we will hear testimony from representatives of the Winfield Moody Health Center, which serves the area around the Cabrini-Green Public Housing complex in my district. I am told that this area has one of the highest infant mortality rates in Illinois, and indeed the Nation. Yet, they experienced no significant increase under the MCH Block Grant Program from 1983 until this year when their allocation was increased by only 6 percent. Although this apparent discrepancy in targeting of funds may be isolated, it certainly warrants our attention.

I am anxious to hear from all of our witnesses today, but before we begin, I would like to thank Chairman Henry Waxman, who is the chairman of our Subcommittee on Health for allowing us to bring these hearings to Chicago. In addition, I want to welcome my congressional colleague who has joined me, Congressman Charles Hayes, who also can take credit for having this hearing here today. He worked very hard because he too told our chairman about how necessary it was that we get some of the problems here in the city of Chicago.

At this time, I recognize my colleague from the First Congressional District, Congressman Hayes.

STATEMENT OF HON. CHARLES A. HAYES, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Mr. HAYES. Thank you very much, Madam Chairwoman. I want to commend you first for your own availability, interest in the subject matter before this committee today.

I do have a prepared statement but rather than to consume time reading it since we have such an impressive and informant list of witnesses I prepare to yield that time that I might consume to them so we can get into the business at hand.

I want to just say that I too want to commend and thank the Chairman Waxman for his agreeing to have your subcommittee come in here. I know it is in good hands and I know he is interested in the environment. As I read in here over the media and I know he is busy at that but this is an important issue to because it has reached a crisis proportion almost here in Chicago. When you look at the traumatic situation where we have no hospital in my district since Michael Reese went out of the business of trauma care so it has reached the part where I think the Federal Government has to look at it. I see no other entity to do it any better than this subcommittee which you are heading today. Thank you very much.

[The prepared statement of Mr. Hayes follows:]

STATEMENT OF HON. CHARLES A. HAYES

Madame Chairwoman, and other members of the subcommittee, I am extremely pleased to be here with you this morning as you convene this most important hearing on health care in Chicago. As you know, although I am not a member of this subcommittee I have had a strong interest in the health care delivery system, especially as it relates to my district and the citizens of Chicago. As a matter of fact, one of the witnesses we will hear from today is Dr. Barbara Norman, chairwoman of my first congressional district health task force. As one of my most active task forces, Dr. Norman's group has been working with me in my efforts in trying to address the health care needs of our community.

Additionally, I especially want to extend my heartfelt thanks to Chairman Waxman for facilitating this hearing. I have been in constant communication with him for quite some time on the health care crisis in Chicago and I am pleased he has agreed to have you convene this Health and Environment Subcommittee hearing here this morning.

Our city has been bombarded with hospital closings in the last several years, and the prospects for this epidemic to subside do not seem to be at hand. As you know, two bright spots on the horizons are the future reopening of Provident Hospital. That is provided that it has not deteriorated too much while being held political hostage by the Federal Government. I have been personally assured by Housing Original Mission, and that is to offer medical care to the citizens in our community. Also, Congresswoman Mary Rose Oakar, D-Ohio, has introduced a bill calling for government-sponsored national health insurance. This bill would guarantee coverage to every citizen through the States, with Federal oversight. It also would provide for long-term care for the elderly, preventive care and increased health research—$258 billion over 5 years is expected to generate support from labor unions.

There is no telling how many people have lost their lives, or are in jeopardy of losing their lives, because of the hospital and trauma center closures. I find it highly upsetting that in this land of plenty, this situation has manifested itself because of the lack of adequate financial resources. As I understand it much of the problem can be attributed to the method in which the State of Illinois finds and administers the Medicaid Program. And, although this may be one factor, Federal funding for the program, or I should say the lack of adequate Federal funding, is also another factor. This is not just going on in our community, this is a national problem. These same problems exist in every urban area.

I am pleased to see that we will hear from representatives of the Illinois Hospital Association and the Metropolitan Chicago Healthcare Council. Both groups have been extremely helpful to me and my staff in keeping us aware of the health care crisis as it relates to their member institutions. In particular, I want to commend IHA for the yearly visits it makes to my Washington office to brief me on their concerns.

Madame Chairwoman, in conclusion, let me also add my commendation to you. Your concern over the health care situation in Chicago has been as strong as, if not stronger than, any other member of our delegation. I think we all owe you a debt of gratitude for your determination to bring about this forum.

I thank you and look forward to hearing the testimony of the scheduled witnesses.

Mrs. COLLINS. Thank you. Let me say that I am sorry that Mr. Waxman is not able to be here. He too asked unanimous consent

that his statement be made a part of the record. Let me say too for all of those witnesses who are not aware of the fact, the House operates under a 5 minute rule and that means the subcommittees must operate the same way. We have a time clock here that we will have set for 5 minutes as soon as the staff member comes up here.

What we will do is this: We want every witness to understand fully that your entire written testimony will be made a part of the official record and you will have 5 minutes in which to summarize that statement or say anything else that you want to say and then we will begin questioning as we go along. We will begin in just a moment.

[The opening statement of Mr. Waxman follows:]

OPENING STATEMENT OF HON. HENRY A. WAXMAN

In February 1988, this subcommittee, at the request of Congresswoman Collins, came to Chicago to hold a hearing on Medicaid prepaid plans. The purpose of the hearing was to learn more about allegations in the Chicago Sun-Times that two prepaid plans were contributing to the city's high infant mortality rate by delivering poor quality care to Medicaid beneficiaries, including high risk newborns.

This morning we are back in Chicago, again at the request of Congresswoman Collins. While infant mortality remains an issue, today we will be looking more broadly at the way in which the State of Illinois administers the Medicaid and the Maternal Child Health [MCH] Block Grant Programs and the consequences for Chicago's low-income communities. In particular, we will be hearing about Illinois' waiver program for contracting with selected hospitals to provide services to Medicaid beneficiaries, and we will be hearing about the allocation of MCH Block Grant infant mortality dollars among different communities within the State.

Both the Medicaid and MCH Block Grant Programs are within the exclusive jurisdiction of this subcommittee. Medicaid is a means-tested Federal-State entitlement program that purchases basic health care services on behalf of low-income families, elderly, and disabled individuals; this year, the Federal Government will spend some $39 billion on Medicaid. In contrast, the MCH Block Grant Program is not an entitlement but a discretionary program of grants to the States targeted on mothers and children, including children with special needs; this year, the Federal Government will spend a total of $554 million on this program.

Although they are underfunded relative to need, both of these programs nonetheless have the potential to improve the health status of low-income communities in Chicago and elsewhere. Today's hearing will examine how successfully the State of Illinois has managed these programs to achieve this goal.

Mrs. COLLINS. Our first panel will consist of Mr. Kenneth Robbins from the Illinois Hospital Association; Mr. Terrence Hansen, Cook County Hospital; Mr. Earl Bird, Metropolitan Chicago Healthcare Council; Mr. John Brown of Bethany Hospital; and Ms. Ruth Rothstein of Mt. Sinai Hospital. Will you come forward please?

Well, I see my friend Don Oder is here. I believe you must be here for the Illinois Hospital Association.

Mr. ODER. I am representing Mr. Robbins, Illinois Hospital Association.

Mrs. COLLINS. Okay, good. Why do we not begin with the Illinois Hospital Association, Mr. Oder.

STATEMENT OF DONALD R. ODER, SENIOR VICE PRESIDENT, RUSH-PRESBYTERIAN-ST. LUKE'S MEDICAL CENTER, ON BEHALF OF THE ILLINOIS HOSPITAL ASSOCIATION; TERRENCE HANSEN, DIRECTOR, COOK COUNTY HOSPITAL; EARL C. BIRD, PRESIDENT, METROPOLITAN CHICAGO HEALTHCARE COUNCIL; AND RUTH ROTHSTEIN, PRESIDENT, MT. SINAI HOSPITAL

Mr. ODER. Thank you, Madam Chairman, Representative Hayes. I am Don Oder, senior vice president, chief operating officer of Rush-Presbyterian-St. Luke's Medical Center on the west side of Chicago. Written testimony has been submitted and I will briefly summarize that.

One week ago today, another innercity hospital closed. You may have not heard about the closing of Central Community Hospital because of other big news stories but let me tell you that this is the 20th Illinois hospital to close since 1985 and I assure you it is big news in Chicago, IL, and particularly it represents a major problem for patients in the affected community and symbolizes Illinois' crumbling health care delivery system.

Why did Central Community Hospital close? Central Community Hospital closed last week largely because of the following patient mix: 30 percent Medicare, 25 percent Medicaid, and 5 percent uninsured. This means that for at least 60 percent of its patients the hospital received less in payment than it cost to treat those patients. A primary reason for the closing of Central Community was Medicaid. In 1987 and 1988 that hospital lost $4 million treating Medicaid recipients, and this is a small hospital.

The losses at Central Community are part of a larger picture. Statewide in 1987 hospitals lost $1.2 billion by treating Medicare, Medicaid, and uninsured patients. In Illinois Medicaid is our biggest problem. Illinois' Medicaid Program pays hospitals, on the average, 70 cents for each dollar of care for inpatients and approximately 50 cents for each dollar cost of care for outpatients.

There are many unfair aspects of the Medicaid Program, however, one problem that occurs day-in-day-out at Rush, as well as other hospitals in the Chicago area, happens in the emergency room. When a recipient is treated in the emergency room, no matter how complex or how intense the service might be, Medicaid pays $99. This system can result in a loss of thousands of dollars on a single patient.

Another example of the unfairness in the Medicaid system is the practice of stopping or slowing payments to providers because a State may be having cashflow problems, the State effectively borrows money from providers.

Medicaid is not about the numbers, or about hospital bottom lines, but it is about helping low-income people get high quality health care. However, when hospitals struggle or close because of an unfair Medicaid system it is the people that suffer.

Now, what can Congress do to help? What can you do to help? The Medicaid enabling statute gives States broad authority over their local programs. Here in Illinois, this authority has allowed the State to secure a waiver and implement the so-called ICARE Contracting Program. This broad authority that helped create ICARE must be examined. The members of the Illinois Hospital

Association believe it is time for the U.S. Congress to intervene and require the State of Illinois to abolish ICARE.

Illinois can no longer tolerate a program that pays hospitals 180 inflation adjusted dollars less per patients than it paid hospitals 10 years ago. Illinois can no longer tolerate its 1987 ranking of last among all States and the District of Columbia in the percentage of cost paid to hospitals for care provided to Medicaid recipients. This subcommittee cannot allow an experiment which has failed people of the State to continue under the cloak of a waiver and Federal authority.

What can happen with a new system? If Illinois implemented a new, appropriately financed, Medicaid system we could organize ambulatory care networks to provide primary care services to Medicaid recipients, we could serve more women and infants by increasing eligibility for programs to 185 percent of the Federal poverty level, and providers could be paid on a more timely basis so as to ensure their financial viability.

On behalf of all Illinois hospitals, I petition you, as members of Congress, to please work with us to do away with the inappropriately named ICARE system and help us implement a fair system so that we continue to provide quality care to the citizens of Illinois.

Madam Chairman, I would be pleased to respond to any questions.

[The prepared statement of Mr. Oder follows:]

TESTIMONY OF DONALD R. ODER, SENIOR VICE PRESIDENT, RUSH-PRESBYTERIAN-ST. LUKE'S MEDICAL CENTER, ON BEHALF OF THE ILLINOIS HOSPITAL ASSOCIATION

A week ago today, another innercity hospital announced it was closing. There was some mention of this in the papers, and the news was broadcast on the radio. But airports and suburban growth and an election in Nicaragua were competing for the media's attention and, once again, health care lost out.

Scant public attention was paid to the fact that the latest hospital to close its doors will be the twentieth, since 1985, to succumb to the crushing pressure of underfunded Medicare and Medicaid Programs and sharply increased numbers of uninsured patients. But, the residents of the south side neighborhood in which this facility was located will feel the absence of their community hospital. The persons who made the 6,200 emergency outpatient visits to the hospital in 1988 may need its health care services again, but the hospital will not be there. The more than 13,000 persons who visited the hospital's clinic or used its outpatient services on a nonemergency basis will have to travel elsewhere to access care—or go without it. And the nearly 2,400 persons who were admitted to the hospital will not have this local health care resource available if they need to be hospitalized in the future.

Was Medicaid the only villain in this story? No. But the Medicaid Program played a villainous role in the demise of this latest hospital to be forced to close. In 1987 and 1988, that one hospital lost more than $4 million treating Medicaid patients, on whose behalf government paid far less than what it cost the hospital to provide recipients with care. More than a quarter of the patients discharged in 1987 were Medicaid recipients; another 30 percent were Medicare recipients; and about 5 percent had no means whatsoever of paying for the treatment they received. So, at least 60 percent of the patients receiving care at this hospital paid less—if anything at all—than what it cost the hospital to provide them with medical care.

Statewide, Illinois hospitals absorbed $1.2 billion in uncompensated care and Medicaid and Medicare shortfalls in 1987. That's right—$1.2 billion worth of health care given away by hospitals which are themselves often on the brink of financial disaster. Why? Because hospitals exist to fulfill a mission in their communities and they continue to do so despite tremendous obstacles. And, one of those obstacles, clearly, is this State's Medicaid Program. The Illinois Medicaid "experiment" has failed the people of this State.

Our Medicaid Program pays hospitals, on average, only 70 cents for each dollar's worth of inpatient care provided and only about half of what it costs a hospital to

provide a Medicaid recipient with outpatient care. Unlike the Federal Medicare Program, which incorporates incentives to reduce length of stay, Illinois' program compensates hospitals on a per diem basis. The perverse incentives of Illinois' Medicaid Program failed to motivate reduced lengths of stay, since hospitals may be able to recover some of the tremendous expense typically incurred in the first few days of an inpatient admission in the lower cost subsequent days of inpatient hospitalization. Implementation of this States' Medicaid Contracting Program has resulted in hospitals that treat more complex cases being paid, on average, less than other hospitals.Perinatal and other specially days are severely limited, despite the fact that such artificial controls jeopardize the ability of the perinatal network to function as the Illinois Department of Public Health intended. Teaching hospitals receive $99—period—for providing emergency room care, even if that care is complicated, extensive, technology-intensive treatment which costs thousands of dollars to provide. To add insult to the injuries inflicted on hospitals by the Medicaid Program, payments to hospitals are delayed when the State runs into cash flow problems. In the next fiscal year, we expect that the State will pay hospitals much less promptly than it currently does; that it will, as a routine matter, balance its checkbook on the backs of hospitals.

But the Medicaid Program is not about the bricks and mortar of hospitals . . . it is about the people they care for, the patients they serve. The young pregnant woman who delivers a healthy baby because she received prenatal care. The victim of a violent crime who is restored to health because of prompt emergency care and available rehabilitation services. The children whose colds remain just that, and do not turn into pneumonia, because they were seen at a hospital-based clinic. We cannot allow the Medicaid system to fail these people and yet, in the city of Chicago and in many rural areas, that is exactly what is occurring. Primary care facilities are an endangered species; the trauma network is losing members; emergency rooms are filled to overflowing; and in all too many communities, there are no hospitals for miles and miles.

The U.S. Congress, in the Medicaid enabling statute, gave the States broad authority to design their local Medicaid Programs. As a result and pursuant to a waiver from certain statutory requirements renewed last year by the Health Care Financing Administration ["HCFA"], the State of Illinois operates its so-called "ICARE" Program. When the waiver was last year being considered for renewal, you Congresswoman Collins, exercised your leadership so that "HCFA" propelled State officials to modify the contracting program to incorporate enhanced payments to disproportionate share hospitals. You also understood the need, and advocated, for a Federal statutory requirement that States operating Medicaid Programs pursuant to a waiver would be required to pay hospitals promptly. We urge you to continue seeking congressional approval of such a requirement. However, we believe that it is time for the U.S. Congress to act to require the State of Illinois to abolish its damaging Medicaid Contracting Program. The people of Illinois can no longer tolerate a Medicaid Program which pays 180 inflation-adjusted dollars less per patient than it paid hospitals 10 years ago. Which forces hospitals into financial chaos. Which resulted in Illinois ranking, in 1987, dead last among all the States and the District of Columbia in the percentage of cost paid to hospitals under its Medicaid Program. It is time to inaugurate a new decade of fairness—for patients and their providers—and a new commitment to compassion for our publicly financed health care programs. But you, our representatives in Congress, must exercise your leadership to make this new decade dawn.

Replacing Illinois' current Medicaid Program with one which provides all our residents with accessible, quality care requires two items which have sometimes been in short supply: money, and the political will to spend it on health care. With improved funding, Illinois could implement a network of organized ambulatory care centers. Illinois could expand eligibility under the WIC Program, as permitted by the Federal law this subcommittee was instrumental in fashioning, to women falling within 185 percent of the Federal poverty level and their infant children. With improved funding, Illinois could pay its health care providers on time, and could replace its counterproductive contracting system with a case-based system of reimbursement for inpatient hospital care.

The State of Illinois must do its share to provide additional funds for the Medicaid Program. To that end, the Illinois Hospital Association has urged members of the Illinois General Assembly to recognize the right of each resident to accessible, quality health care by appropriating the funds necessary for our residents to secure that right. We have constantly reminded our State legislators how many Federal dollars they lose by shortchanging the Medicaid Program. We have worked long and hard with officials in the executive branch of government to improve and strengthen our

Medicaid system and participate in the ongoing Cook County Health Care Summit. But today, we petition Congress, through you, to help us preserve the very lifeblood of our State: a healthy, productive population of persons who have access to health care. We implore you who have jurisdiction over, and responsibility for, our Medicaid Program, to do what is necessary, and to do what is right for the people of Illinois and throughout this nation. Make health care a priority; whether it be viewed as share in the "peace dividend"; an investment in the future; or fulfillment of a promise this country has made to its people, give the States the means with which to conduct adequate Medicaid Programs and clear, positive and forceful direction about the manner in which those programs must be conducted. Chairwoman Collins, help hospitals do what we—and you—wish to do for your constituents and all the people of this State. Join us in bringing new hope to health care in the 1990's and beyond.

Mrs. COLLINS. Thank you very much. Mr. Hansen, Cook County Hospital.

STATEMENT OF TERRENCE HANSEN

Mr. HANSEN. Thank you, Madam Chairman, Congressman Hayes. I suspect that most of the witnesses this morning will talk to you about the reforms in the Medicaid Program and what is required and the basic inequities in the funding process. So, if I may, I will take at liberty your opening remarks, Congresswoman Collins, about talking about some other things that are of grave concern to us as well.

In the eventuality that the Congress is able to make the kinds of corrections in conjunction with State governments in the Medicaid Program we still may have a very significant health care crisis in the city of Chicago. It is a little bit like if we give a party but nobody comes, if we have adequate Medicaid reimbursement but there is nobody available to provide health care what good does it do us if the rate of reimbursement has been significantly altered or improved?

As you may know, Cook County Hospital has just about completed its labor negotiations with the Illinois Nurses' Association and a new contract is being put together now which will be put before the nurse membership. However, I want to bring to your attention that just a few weeks ago, because the negotiations were getting close to an impasse, County was faced with a slowdown in the utilization of overtime by our employed nurses. We have about 15 percent vacancies right now at Cook County Hospital and to fill those vacancies we use either registry services or overtime. If our employees do not use the overtime then we basically are getting shorter on staff than our current vacancies.

When you made reference to burn and to trauma earlier, we have been on burn bypass more times than not since the first of the year. And we are on bypass solely because we do not have the filled nursing positions to provide that level of care.

I think the second thing that you need to take into consideration is that County, again, can have very very significant swings in its census. I am not sure how many hospitals in metropolitan Chicago can change their census by 20 percent in 72 hours. When that happens County's ability to respond to that changing census is, again, determined by the number of positions that we have and the willingness of our employees to use the overtime opportunities.

It was one of Mr. Oder's vice presidents who said that when Cook County Hospital gets a cold everyone around it sneezes. If County

is not able to operate as a full functioning tertiary care hospital, if its emergency room is on bypass, if its burn unit is on bypass, if its trauma service is on bypass, then the burden shifts to community and tertiary care hospitals that surround us. They shift to places like Rush, they shift to places like Mt. Sinai and that gets us right back to the start of the problem again with the Medicaid reimbursement formula.

You cannot continue to expect providers, like a Rush, and like a Mt. Sinai, to continue to provide a level of care expected of them and every single time they do it they are getting less than 70 cents on the dollar for reimbursement rates. Until that is adjusted we are going to continue to be in the same state of crisis we are.

I would suggest that when you go back to Washington, you not only consider the inequity in the funding process but at the national level we have got to begin to address the problems of the nursing crisis in this country. You have gotten reams of material from various associations, from various interest groups, I would suggest to you they are merely understating the problem, it is going to get worse, it is not going to get better. No matter what your reimbursement rate is, until this country is in a position to begin to fill vacant nurse positions, you will continue to have a crisis in health care in the innercity.

I will be very happy to deal with any other questions you make care.

Mrs. COLLINS. Mr. Bird.

STATEMENT OF EARL C. BIRD

Mr. BIRD. Good morning, Chairwoman Collins.

Mrs. COLLINS. Good morning.

Mr. BIRD. Congressman Hayes and other members of the committee. I am Earl Bird. I am president of the Metropolitan Chicago Healthcare Council, speaking on behalf of 94 hospitals located in the metropolitan Chicago area. We appreciate the opportunity to write comments. In the interest of time, I am going to restrict my comments or put the main focus of my statements to be on Medicaid underfunding, especially as it relates to emergency and trauma services.

As we enter this new decade of the 1990's, residents of metropolitan Chicago are faced with a health care delivery system that does not meet the primary health care needs of too many of us; a system that has emergency departments operating at beyond capacity, causing ambulances to bypass as many as 13 area hospitals before it can deliver a patient; that has 4 out of 10 trauma centers closed, leaving a void of such care on the south side; and that has seen 14 hospitals, as already previously mentioned, close since 1985 in the metropolitan Chicago area, primarily in the city, many of which were serving the communities now desperately in need of health care. These hospitals all had one thing in common: they treated the poor and the elderly.

There is no business in this world that can remain fiscally viable if it were told to receive less than cost for the majority of the services provided. Moreover, Medicare and Medicaid now represent 55 percent of the payor mix for city of Chicago hospitals in 1988. That

percentage will probably increase when 1989 figures are released. Patient service operating margins in 1987 were a negative 12 percent for the city of Chicago hospitals. This is the environment the hospital trauma centers and emergency departments must function in. In this context, let me briefly explain the history of the trauma network.

In 1987 the city council passed the trauma ordinance and the accompanying regulations and procedures for implementation. Originally there were 10 health care facilities designated. Since the inception of the network, four trauma centers have left the program: University of Chicago, Louis A. Weiss, Loyola University, and Michael Reese Medical Center.

A level I trauma center is a hospital designated for around-the-clock comprehensive care for life-threatening injuries. Each trauma center must be staffed with surgeons specialized in trauma, neurosurgery and other specialties to provide medical care for any type of injury.

As Terry has just stated, we have tremendous staffing problems. There must be operating rooms, intensive care services, blood supplies, and other state of the art life saving equipment all dedicated to the optimum care of the victim.

The overall goal is to reduce the mortality, and frankly, we have been very successful in that. The Chicago Trauma Center had a survival rate of 76.1 percent among severely injured level I trauma victims in 1987. This has increased to 78 percent in 1988. The system does work. Unfortunately, it is extremely expensive to provide to the citizens. By definition, level I trauma are the most severely injured of those suffering from penetrating trauma and thus require a greater array and intensity of services. Financial estimates are that an average cost to a hospital for a level I patient is $10,000, twice that of an average patient.

While costs of trauma are disproportionately high, payment rates tend to be extremely low. The estimated average loss to hospitals is $6,000 for level I patient based on an average cost of $10,000. This average is based on a wide-range level of payments, from medically indigent from whom no payment is received all the way for a relatively favorable payment of a Blue Cross patient and so on.

Approximately 34 percent of all level I patients are Medicaid patients. Medicaid pays at 46 percent of cost, on average, for trauma patients. And the loss attributed to Medicaid underfunding is approximately $2.1 million in this city alone. This situation is compounded by the fact that for each dollar lost through the Medicaid Program, there is a loss of a Federal matching dollar.

In effect, Medicaid underpayment is responsible for the single largest loss to the trauma system. Medicaid payments for trauma patients should better reflect the high cost of providing care to traumatized patients.

The problem in trauma care is further complicated by the enormous overload experience by emergency departments. Emergency department visits are continually on the rise, that is true in all hospitals as well as emergency rooms.

The emergency room is frequently the only accessible health care site for many residents. In 1988, hospitals in metropolitan Chicago had over 2,463,000 emergency room visits.

[Testimony resumes on p. 24.]

[The prepared statement of Mr. Bird follows:]

METROPOLITAN CHICAGO HEALTHCARE COUNCIL

MR. CHAIRMAN, REPRESENTATIVE COLLINS AND MEMBERS OF THE SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT, I AM EARL C. BIRD, PRESIDENT OF THE METROPOLITAN CHICAGO HEALTHCARE COUNCIL (MCHC), SPEAKING ON BEHALF OF OUR NINETY-FOUR HOSPITAL MEMBERS. THE COUNCIL APPRECIATES THE OPPORTUNITY TO EXPRESS THE VIEWS OF THE METROPOLITAN CHICAGO HOSPITAL COMMUNITY AT THIS HEARING ON MEDICAID AND MATERNAL AND CHILD BLOCK GRANTS. THE MAIN FOCUS OF MY STATEMENT WILL BE ON MEDICAID UNDERFUNDING OF EMERGENCY AND TRAUMA SERVICES.

AS WE ENTER INTO THIS NEW DECADE OF THE 1990s, RESIDENTS OF METROPOLITAN CHICAGO ARE FACED WITH A HEALTH CARE DELIVERY SYSTEM THAT DOES NOT MEET THE PRIMARY HEALTH CARE NEEDS OF TOO MANY OF US; A SYSTEM THAT HAS EMERGENCY DEPARTMENTS OPERATING AT BEYOND CAPACITY, CAUSING AMBULANCES TO "BYPASS" AS MANY AS THIRTEEN AREA HOSPITALS; THAT HAS FOUR OUT OF TEN TRAUMA CENTERS CLOSED, LEAVING A VOID OF SUCH CARE ON THE SOUTH SIDE; AND THAT HAS SEEN FOURTEEN HOSPITALS CLOSE SINCE 1985, MANY OF WHICH WERE SERVING COMMUNITIES NOW DESPERATELY IN NEED OF HEALTH CARE.

THERE IS NO BUSINESS THAT COULD REMAIN FISCALLY VIABLE IF IT WERE TO RECEIVE LESS THAN COSTS FOR THE MAJORITY OF THE SERVICES PROVIDED. MOREOVER, MEDICARE AND MEDICAID REPRESENTED 55 PERCENT OF THE PAYOR MIX FOR CITY OF CHICAGO HOSPITALS IN 1988. PATIENT SERVICE OPERATING MARGINS IN 1987 WERE A NEGATIVE 12 PERCENT FOR CITY OF CHICAGO HOSPITALS.

THIS IS THE ENVIRONMENT IN WHICH HOSPITAL TRAUMA CENTERS AND EMERGENCY DEPARTMENTS MUST FUNCTION. IN THIS CONTEXT, LET ME EXPLAIN THE BRIEF HISTORY OF THE CHICAGO TRAUMA NETWORK. IN 1986, THE CHICAGO CITY COUNCIL PASSED THE TRAUMA ORDINANCE AND THE ACCOMPANYING REGULATIONS AND PROCEDURES OF IMPLEMENTATION.

ORIGINALLY, TEN ADULT TRAUMA CENTERS WERE DESIGNATED:

LUTHERAN GENERAL HOSPITAL

LOYOLA UNIVERSITY MEDICAL CENTER

CHRIST HOSPITAL AND MEDICAL CENTER

COOK COUNTY HOSPITAL

ILLINOIS MASONIC MEDICAL CENTER

MICHAEL REESE HOSPITAL AND MEDICAL CENTER

MOUNT SINAI HOSPITAL MEDICAL CENTER

NORTHWESTERN MEMORIAL HOSPITAL

UNIVERSITY OF CHICAGO HOSPITALS

LOUIS A. WEISS MEMORIAL HOSPITAL

SINCE THE INCEPTION OF THE NETWORK, FOUR TRAUMA CENTERS HAVE LEFT THE PROGRAM:

UNIVERSITY OF CHICAGO HOSPITALS

LOUIS A. WEISS MEMORIAL HOSPITAL

LOYOLA UNIVERSITY MEDICAL CENTER

MICHAEL REESE MEDICAL CENTER

A LEVEL I TRAUMA CENTER IS A HOSPITAL DESIGNATED BY THE CHICAGO DEPARTMENT OF HEALTH WHICH IS CONSISTENT WITH NATIONAL STANDARDS ESTABLISHED FOR IMMEDIATE, AROUND-THE-CLOCK, COMPREHENSIVE CARE OF LIFE-THREATENING INJURIES. EACH TRAUMA CENTER MUST BE STAFFED WITH SURGEONS SPECIALIZED IN TRAUMA, NEUROSURGERY AND OTHER SPECIALTIES TO PROVIDE EMERGENCY AND MEDICAL CARE FOR ANY TYPE OF INJURY. THERE MUST BE OPERATING ROOMS, INTENSIVE CARE SERVICES, BLOOD SUPPLIES, AND OTHER STATE-OF-THE-ART, LIFE-SAVING EQUIPMENT, ALL DEDICATED TO THE OPTIMAL CARE OF THE TRAUMA VICTIM.

THE OVERALL GOAL OF THE CHICAGO TRAUMA SYSTEM IS TO REDUCE THE MORTALITY OF TRAUMA THROUGH A SYSTEM WHICH GETS THE MOST SEVERELY INJURED PATIENT TO THE BEST-EQUIPPED HOSPITAL IN THE SHORTEST TIME. IN REVIEWING EFFECTIVENESS, THE CHICAGO TRAUMA SYSTEM HAD A SURVIVAL RATE OF 76.1 PERCENT AMONG SEVERELY INJURED LEVEL I TRAUMA VICTIMS IN 1987, WHICH HAS INCREASED TO NEARLY 78 PERCENT IN 1988. THIS COMPARES FAVORABLY WITH OTHER TRAUMA SYSTEMS IN THE NATION.

COMPARED TO OTHER INPATIENT CARE, THE COSTS OF TRAUMA CARE ARE VERY HIGH. BY DEFINITION, LEVEL I TRAUMA PATIENTS ARE THE MOST SEVERELY INJURED OF THOSE SUFFERING FROM PENETRATING AND BLUNT TRAUMA, AND THUS REQUIRE A GREATER ARRAY AND INTENSITY OF SERVICES THAN OTHER TRAUMA VICTIMS.

AT THIS POINT, IT IS DIFFICULT TO ASSESS THE OVERALL FINANCIAL IMPACT OF LEVEL I TRAUMA PATIENTS ON CHICAGO TRAUMA CENTERS, GIVEN THE LEVEL OF AGGREGATE DATA NOW AVAILABLE TO US AND THE DIFFERING METHODS OF COST ACCOUNTING USED BY HOSPITALS. FINANCIAL ESTIMATES ARE THAT AN AVERAGE COST TO A HOSPITAL FOR A LEVEL I PATIENT IS $10,000, TWICE THAT OF THE AVERAGE INPATIENT STAY.

LEVEL I INPATIENT CARE IN CHICAGO IS CURRENTLY FINANCED IN A NUMBER OF WAYS, DEPENDING ON THE FINANCIAL STATUS OF THE PATIENT AND THE TYPE OF FACILITY WHERE THE CARE IS RENDERED. ACCORDING TO 1987 DATA FROM A LIMITED NUMBER OF LEVEL I HOSPITALS (NOTABLY EXCLUDING COOK COUNTY HOSPITAL, WHICH SEES A DISPROPORTIONATE NUMBER OF MEDICALLY INDIGENT AND MEDICAID PATIENTS), LEVEL I PATIENTS FALL INTO THE FOLLOWING CATEGORIES:

CATEGORY	PERCENT OF LEVEL I PATIENTS
BLUE CROSS	7%
MEDICARE	9%
MEDICAID/MANG	34%
COMMERCIAL	33%
SELF-PAY*	10%
OTHER**	10%

* NO INSURANCE WITH AT LEAST 8% OF TOTAL BEING ZERO PAY
**E.G., HMO, PPO, WORKER'S COMPENSATION

WHILE COSTS OF TRAUMA CARE ARE DISPROPORTIONATELY HIGH, PAYMENT RATES TEND TO BE EXTREMELY LOW. THE ESTIMATED AVERAGE LOSS TO HOSPITALS IS $6,000 PER LEVEL I PATIENT, BASED ON AN AVERAGE COST OF $10,000. (THIS FIGURE IS CURRENTLY BEING UPDATED.) THIS AVERAGE IS BASED ON A WIDE RANGE OF LEVELS OF PAYMENT -- FROM THE MEDICALLY INDIGENT FOR WHOM NO PAYMENT IS RECEIVED, ALL THE WAY TO RELATIVELY FAVORABLE PAYMENT FROM BLUE CROSS AND COMMERCIAL INSURANCE.

WITH THE ADOPTION OF DIAGNOSTIC-RELATED GROUPS (DRGs) AS THE BASIS OF MEDICARE PAYMENT, MEDICARE PAYMENT FOR TRAUMA PATIENTS HAS FALLEN FAR SHORT OF COSTS. EVEN THOUGH SPECIFIC DRGs ARE DESIGNATED FOR TRAUMA CARE (CATEGORIES 444, 445, AND 446), PAYMENTS FOR THESE CATEGORIES DO NOT ACCOUNT FOR THE SEVERITY OF THE MULTIPLE INJURIES, NOR, THEREFORE, FOR THE LENGTH OF STAY AND COSTS. BECAUSE OF ILLINOIS' CURRENT SYSTEM OF PAYMENT THROUGH ICARE AND HISTORICAL UNDERPAYMENT OF HEALTH SERVICES, MEDICAID IS THE CAUSE OF A SIGNIFICANT PORTION OF UNDERPAYMENT. ONLY SELECTED DIAGNOSES OF TRAUMA CURRENTLY FALL UNDER ICARE'S HIGHER LEVEL OF PAYMENT FOR SPECIALTY CARE.

APPROXIMATELY 34 PERCENT OF ALL LEVEL I PATIENTS ARE MEDICAID PATIENTS. MEDICAID PAYS AT 46 PERCENT OF COSTS ON AVERAGE FOR TRAUMA PATIENTS AND THE LOSS ATTRIBUTED TO MEDICAID UNDERFUNDING IS APPROXIMATELY $2.1 MILLION. THE SITUATION IS COMPOUNDED BY THE FACT THAT FOR EACH DOLLAR LOST THROUGH THE MEDICAID PROGRAM, THERE IS THE LOSS OF A FEDERAL MATCHING DOLLAR.

IN EFFECT, MEDICAID UNDERPAYMENT IS RESPONSIBLE FOR THE SINGLE LARGEST LOSS TO THE TRAUMA SYSTEM. MEDICAID PAYMENTS FOR TRAUMA PATIENTS SHOULD BETTER REFLECT THE HIGH COST OF PROVIDING CARE TO TRAUMATIZED PATIENTS. THE ICARE RATES SHOULD BE MODIFIED SO THAT A SPECIAL ICARE RATE IS ESTABLISHED FOR LEVEL I TRAUMA CENTERS. ADDITIONALLY, LEVEL I TRAUMA HOSPITALS SHOULD RECEIVE HIGHER RATES FOR EMERGENCY DEPARTMENT SERVICES TO HELP DEFRAY THE ADDED COST ASSOCIATED WITH THE AVAILABILITY OF SOPHISTICATED TECHNOLOGY AND PERSONNEL.

THE PROBLEM IN TRAUMA CARE IS FURTHER COMPLICATED BY THE ENORMOUS OVERLOAD EXPERIENCED BY EMERGENCY DEPARTMENTS. EMERGENCY DEPARTMENT VISITS ARE CONTINUALLY ON THE RISE. THE EMERGENCY DEPARTMENT IS FREQUENTLY THE ONLY ACCESSIBLE HEALTH CARE SITE FOR MANY AREA RESIDENTS. IN 1988, HOSPITALS IN METROPOLITAN CHICAGO REPORTED 2,463,987 EMERGENCY DEPARTMENT VISITS.

MANY PATIENTS CURRENTLY BEING TREATED IN THE EMERGENCY DEPARTMENT ARE THOSE WHO LACK ANY OTHER APPROPRIATE ACCESS TO PRIMARY CARE IN OUR HEALTH CARE SYSTEM. PRIVATE PHYSICIANS AND CLINICS MUST RECEIVE ADEQUATE MEDICAID PAYMENT IN ORDER TO PROVIDE THEM INCENTIVES TO TREAT THIS POPULATION BEFORE A MINOR ILLNESS EVOLVES INTO AN ACUTE CARE CRISIS.

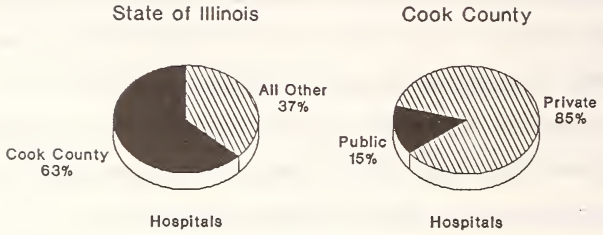
MAJOR DECISIONS MUST BE MADE AS TO THE FUTURE OF THE MEDICAID PROGRAM. CURRENTLY, MEDICAID PATIENTS DO NOT EXPERIENCE APPROPRIATE ACCESS TO NEEDED PRIMARY SERVICES. AS A RESULT, THEY MUST OBTAIN THESE SERVICES THROUGH HOSPITAL EMERGENCY DEPARTMENTS. IN ADDITION, ACCESS TO SPECIALITY SERVICES IS INCREASINGLY LIMITED BECAUSE HOSPITALS CANNOT AFFORD TO STAFF THE NECESSARY BEDS OR CARE FOR THE DEMAND BY PATIENTS BECAUSE THEY SIMPLY CANNOT AFFORD THE OVERWHELMING LOSSES.

THE QUESTION IS: DO WE ACCEPT A TWO-TIERED SYSTEM OF HEALTH CARE? IF SO, WHAT ARE THE BASIC OR ESSENTIAL SERVICES THAT GOVERNMENT IS WILLING TO ADEQUATELY PROVIDE? IF WE AGREE NOT TO ACCEPT A TWO-TIERED SYSTEM OF CARE, THEN WE MUST PROVIDE ACCESS TO HEALTH CARE FOR THIS SECTOR OF THE POPULATION THROUGH ADEQUATE GOVERNMENT FUNDING.

THE COUNCIL AND ITS MEMBERS STAND READY TO WORK WITH THIS COMMITTEE TO FIND SOLUTIONS TO THESE PROBLEMS.

MEDICAID DAYS

1988



	DAYS IN CHICAGO	*PERCENT OF CHICAGO*	*PERCENT OF COOK COUNTY*	*PERCENT OF ILLINOIS*
Public Hospitals	107,619	15.2%	15.0%	8.2%
Private Hospitals	601,106	84.8%	85.0%	91.8%
Total	708,725	100.0%	100.0%	100.0%
State of Illinois Hospitals	1,604,593	44.2%	54.6%	

Public Hospitals include Cook County, University of Illinois, and Oak Forest.

Source: AHA Annual Survey of Hospitals

IMPACT OF MEDICARE AND MEDICAID PAYMENTS

Metropolitan Chicago Hospitals

- The **majority** of Metropolitan Chicago Hospitals **lose money** on patient care.

- The **hospital mean** is projected at **$0.90** on a dollar of **cost** in fiscal year 1990 from Medicare.

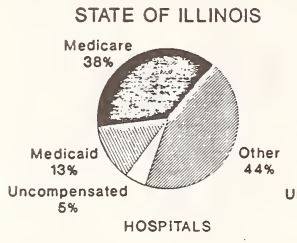
- More than **seventy five percent** of all hospitals will **lose money** caring for **Medicare** patients.

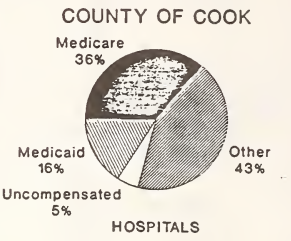
- In 1990 the average State of Illinois payment for Medicaid is projected to be **$0.72** on a dollar of **cost**. Projected payments to Metropolitan Chicago hospitals for 1990 are **$0.67** on a dollar of **cost**.

- In the city of Chicago (44 hospitals) the average hospital receives **55%** of its patient revenue from government services. (33% Medicare and 22% Medicaid)

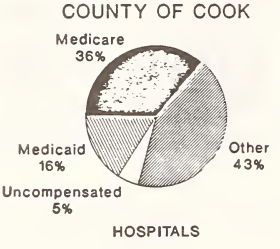
Source: MCHC

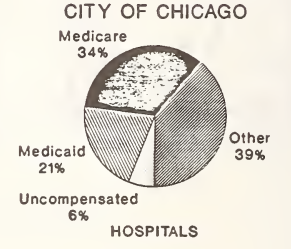
PAYOR MIX
1988



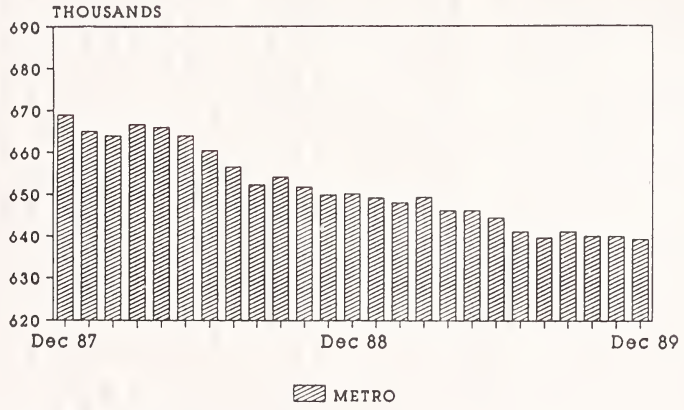


BASED ON GROSS CHARGES





PUBLIC AID RECIPIENTS
DECEMBER 1987 - DECEMBER 1989



SOURCE: ILL DEPARTMENT OF PUBLIC AID

METROPOLITAN CHICAGO

- 639,250 recipients in December 1989
- Down 1.7 percent from December 1988

CITY OF CHICAGO

- 76,895 general assistance recipients in December 1989
- Down 1.2 percent from December 1988

Mrs. COLLINS. Ms. Rothstein.

STATEMENT OF RUTH ROTHSTEIN

Ms. ROTHSTEIN. Good morning.

Mrs. COLLINS. Good morning.

Ms. ROTHSTEIN. Thank you, Madam Chairperson, Representative Hayes. I appreciate the invitation you have extended to me to speak on behalf of Mt. Sinai. I want to talk not about the Medicaid underfunding because we have already heard about that but I do want to talk a little bit about Medicare and the trauma system which you are also aware of but I wanted to bring again into focus because we—treating the city's most severely injured victims.

Between California and 15th Street is along that area where violent crime is an everyday occurrence. The victims of violent crime who come into our trauma unit are expensive to treat and the majority have no insurance to speak of. For many reasons they may not even qualify for insurance, many are unemployed and many others are on public aid. As the nearest hospital to the Eisenhower-Dan Ryan Expressway junction we receive most of the serious injured from multivehicle accidents. Yet, we continue to carry out our mission as an urban center and treat everyone who walks through the doors regardless of their ability to pay.

Mt. Sinai, like every other hospital in the city trauma system is paying dearly to provide the best care and we are losing millions of dollars in the process. Hospitals in the Chicago trauma system virtually swallowed $10 million last year because the majority of people served in our emergency rooms are the indigent who are on Medicaid or underinsured.

Last year Mt. Sinai had a net loss of approximately $2 million. Half of that figure can be attributed to the adult severe trauma patients brought into our emergency rooms. The average dollar loss for a trauma case at Mt. Sinai is $5,500, that is $5,000 worth of supplies, blood tests, CAT scans, and medical skills provided by our hospital that then must absorb the loss. The most severely injured victims may require costs of $15,000 per case. We are overcrowded and overburdened and we cannot rely on Medicare and Medicaid in their present state to pickup our financial pieces.

Hospitals in this area cannot continue to operate by receiving only 89 cents for every dollar it takes to treat a Medicare patient. On this, the 25th anniversary of Medicare, we would love to celebrate a reimbursement system that really works but Medicare falls short of its promise. The Medicaid picture is even dimmer.

An innercity hospital such as ours receives only 70 cents for every dollar spent to treat a Medicaid patient and less than 50 percent of our emergency room costs. Mt. Sinai has the desire and the commitment to continue to serve our community by providing access to the best possible health care but this mission cannot be carried out without an infusion from the Federal Government.

It is not possible for Illinois hospitals to continue to provide $600 million in uncompensated care each year. The government has a responsibility to provide for its people but has not moved into the driver's seat in providing matching funds for health care. Illinois ranks last on actual dollars received versus tax dollars paid.

Twenty hospitals in Illinois have closed, and it is now 21, mostly because they could not survive financially.

Our shrinking trauma network is another vivid example of hospitals curtailing essential services because they can no longer afford to cover their financial losses. The number of emergency rooms in this city is shrinking. Emergency patients with less serious illness and injury wait for hours for treatment as the volume of trauma patients increases on any given day. We are doing everything we can with the limited resources we have.

If Federal underfunding continues the services and care we can provide will decrease. We will not turn people away but we are strapped. We cannot continue to stand in line with head in hand and hope to be bailed out. We need your support and need immediate action that will send Federal money into the Chicago trauma system.

What we have continued to do is to chip away at the system called health care delivery. It is time to make this issue a national agenda item and we must find it a solution. How can we talk about Eastern Europe and democracy and continue to ignore the fact that 300 million Americans do not have a health care delivery system that is not fragmented.

It reminds me of a song that I just learned from my grandchild about six little ducks going over the hill and around the town and each time they went over the hill and around the town one less came back. Thank you.

Mrs. COLLINS. Thank you. Mr. Hansen, we appreciate the fact that you made us very aware of the fact that we have very few nurses, that you have to close down certain beds in the hospital because you do not have sufficient nurses to service those beds. One of the things I wondered about the Cook County Hospital is you mentioned about the bypass, the trauma bypass, that we had reference to.

A case came up a couple of weeks ago I think I heard about it from the Wyler Memorial Hospital and it seems that Wyler's emergency room had gone into the bypass status and that there was a little baby girl brought there who was in respiratory arrest and that her parents or whoever it was took her from location to another and finally ended up at the Cook County Hospital and when she got there I guess she was pronounced DOA. These are the kind of tragic things that we hear about. Now, when Cook County goes on bypass, what happens?

Mr. HANSEN. Two levels actually, Congresswoman. The first is when we go on a bypass we notify the city fire department paramedic system that they are to divert their vehicles and patients to other institutions. At the same time, we also notify private ambulances not to bring transfer patients or patients to County. That does not shut down the emergency room, however, because one of the problems you run into is that many many people who are either injured or severely ill will be brought to the emergency room by family members or they will attempt to get there on their own sometimes by things like public transportation. It takes us out of the organized system, per se, but it does not take us out of the business even while we are on a bypass.

Mrs. COLLINS. Mr. Oder, would you know how many other States have waivers such as we have in the State of Illinois?

Mr. ODER. No, I do not. The only State that I know of that has the contracting system that we have is the State of California.

Mrs. COLLINS. And would you know what their experience has been?

Mr. ODER. No, I do not.

Mrs. COLLINS. Ms. Rothstein, you spoke about at this point in time that you have experienced a $2 million deficit, if you will, in providing service because of the slowness of the Medicaid Program and the fact that you are not fully reimbursed for the care that you give. My question has to be: How do you keep your doors open?

Ms. ROTHSTEIN. With difficulty. We are being actually in a sense subsidized by the vendors. We do not pay our bills on time. We are paying our bills at the rate of 180 days. We are constantly switching it, we are robbing Peter to pay Paul. What we are finding is that the vendors are really subsidizing the institution, the question becomes: How long are they going to be willing to do this? And how long can we survive in that kind of an environment?

Mrs. COLLINS. Now, I think someone mentioned that four trauma network participants have fallen out of the system, is that right?

Mr. BIRD. That is correct.

Mrs. COLLINS. You mentioned that, Mr. Bird?

Mr. BIRD. Yes.

Mrs. COLLINS. How many are left in the city of Chicago?

Mr. BIRD. Six.

Mrs. COLLINS. Only six?

Mr. BIRD. Yes.

Mrs. COLLINS. Do you think they are able to handle the volume that they have?

Mr. BIRD. Well those six trauma systems have gone out of their way to work with the fire department and so forth to redesign and change the geographics in order to be able to handle the load. But at times, they too are reaching the level which they are unable to meet the needs and therefore they go into bypass just like any other emergency room as Terry Hansen has already mentioned.

The problem with the number, the biggest problem, is that they are not geographically dispersed throughout the city into the proper locations in order to be able to handle the number of trauma patients. So the answer is: In some parts of the city I would have to say no, in other parts it may be appropriate at this point in time.

Mrs. COLLINS. When Michael Reese announced that it was no longer going to be providing trauma care services some of us thought that Cook County Hospital was going to pickup the slack. Has this been the case, Mr. Hansen?

Mr. HANSEN. Actually not. It has been a surprise. I think what is happening is, first of all, Northwestern Hospital extended its boundaries south a considerable distance. It originally stopped its catch of an area at 12th Street and it has gone down to 63rd Street. County, itself, has not had a dramatic increase and I do not believe Christ has. Ms. Rothstein may address this as well because the other hospital that would have been expected to pickup a significant increase from the Reese closure would have been Mt. Sinai.

Mrs. COLLINS. Ms. Rothstein, let me ask you, nobody has talked about the President's proposed budget and I wonder if you can tell us how you think that the new budget is going to impact on the hospitals, particularly the part about proposed Medicare cutbacks in funding for indirect medical education and for graduate medical education.

Ms. ROTHSTEIN. Yes, thank you. It is a very serious problem and it is a very serious problem for all institutions that are in teaching but it becomes a particularly serious problem for Mt. Sinai in the sense that I cannot tell you specifically how many dollars we at Mt. Sinai use but there would be a loss of about $117 million into the State, that is the estimated impact on the proposed Medicare cuts. What would happen to an institution like Mt. Sinai, we are heavily dependent on our physicians who are faculty members to teach and treat patients. If these Medicare cuts continue for graduate medical education, indirectly or directly, our physicians will not be able to stay in the innercity and practice medicine. They are currently not even competitive with the voluntary physicians who have offices throughout the State and throughout the city so that it becomes an additional burden for us. If these cuts are allowed to go through we in the urban center will suffer tremendously.

Mrs. COLLINS. It is my understanding that if there are cuts in the indirect medical education adjustments that you would be cut approximately in half of what you are now receiving under the program and therefore, if considering these cutbacks will special attention have to be given to preserve any current rates for disproportionate share hospitals which would be devastated by further cuts?

Ms. ROTHSTEIN. I think the answer is obviously that will be an imperative that the disproportionate share piece of the Medicare financial component remain in place because if that is taken out of the system, if that piece is taken out of the system for all urban teaching hospitals we will suffer even more and we will lose in the metropolitan Chicago area there will be a loss of approximately $55 million if the budget cuts are implemented. This then has its immediate effect on hospitals like Mt. Sinai who are in the teaching business, as it were, as well as in the patient care delivery system. So it has its effect not only on Mt. Sinai, it will have its effect on Rush, it will have its effect on Northwestern, it will have its effect on Loyola and these are all institutions that deal with indigent patients.

Mrs. COLLINS. Mr. Bird, several years ago excess hospital capacity seemed to be a key issue around here. Can you tell us how recent hospital closings have impacted on this excess capacity that we thought we had?

Mr. BIRD. Well, I think in the last 4 or 5 years the hospitals in general have all reduced their capacity, a majority of them in excess of about 25 to 30 percent. What has not changed is that the 13 or 14 hospitals that have closed patients that went to those hospitals they have not disappeared from the scene. They have an effect, are now showing up at the doorsteps of the hospitals that remain and they are uncompensated or inability to pay for their own health care. So what we have done is shifted the burden to the next hospitals. What we have going on here in the city is the

domino effect. As the patients leave Central Community as of March 14 they will then show up at the steps of the neighboring hospitals and so forth.

I believe the argument of excess capacity is over with. We do not have enough capacity. That is especially true and especially surfaces such as emergency room where you would not have 14 to 15 hospitals shut down their emergency room every other day.

Mrs. COLLINS. Ms. Rothstein, a couple of weeks ago, I believe it was——

Ms. ROTHSTEIN. I am sorry, I did not hear that.

Mrs. COLLINS [continuing]. I think it was a week or so ago I attended a function that you had at Mt. Sinai hospital and I believe the purpose of it was to raise funds to provide more equipment for low birthweight babies. Do you want to tell us a little bit about that? And I would like for you if it is possible to tell us why there was a need to have this fund raiser if ICARE is doing its responsible thing.

Ms. ROTHSTEIN. We at Mt. Sinai, again, because of our financial plight and because of our inability to borrow money we have an inability to access money for capital and in order for Mt. Sinai to upgrade, in order for Mt. Sinai to keep ahead of the technology, in order for us to deal with the low weight babies and getting monitors et cetera, we have needed to raise funds. We do not spin off any cash from our revenue stream therefore, in order to get equipment, in order to upgrade, this is not even being out in front this is merely upgrading, to take care of the patient population that comes to us we need to raise funds. We cannot and we will not be able to in the foreseeable future to expend any money that has been raised by outside resources.

Mrs. COLLINS. Is there an increasing number of patient population in the hospital regarding babies of low birthweight?

Ms. ROTHSTEIN. Yes. Our infant intensive care is always jammed to the gills. The problem we have with trying to run it because we do not have the proper health manpower that Mr. Hansen talked about. That is a very serious problem because we have the use of 22 beds and we are only operating 15 because we do not have the nurses.

Mrs. COLLINS. Mr. Hayes.

Mr. HAYES. Thank you, Madam Chairman. I am missing two statements which I would like to have, you Ms. Rothstein, and I think Mr. Hansen. Do you have copies of the statement you presented for the committee?

Mr. HANSEN. I do not have one with me.

Mr. HAYES. Would you see that one is available?

Ms. ROTHSTEIN. I have one.

Mr. HAYES. Okay. Thank you very much. It would be helpful.

Mrs. COLLINS. Do you have it now?

Ms. ROTHSTEIN. Yes.

Mrs. COLLINS. Sara, would you get it please?

Mr. HAYES. Now, I have one question I want to direct to all four of the witnesses. What do you see is the alternative in terms of impact on victims if we continue to drag along Federal, State, and county government and not do anything that—correct the situation that exists in terms of inability to deliver health care to people

who need it, particularly those who are involved in traumatic situation? What do you see is going to happen? Do you see an increased number of unnecessary deaths? I want to get it into the record if you feel it. Either one, all of you.

Ms. ROTHSTEIN. I think the answer is: Yes. I think that one of the things that has happened, interestingly enough, over the years is that because the cuts, Representative Hayes, because of the cuts at both the Federal level and at a State level, there are whole groups of people who have gotten lost in the system. Nobody really knows what happened to them. As the Medicaid cuts took place it was interesting that there was a reduction in the numbers of people that they were covering. Now, obviously, these people are still somewhere and I think what happens is that out in the rural areas as well as in the urban areas these people eventually show up in emergency rooms when they are at end stage in their health. So I believe that the health of the Nation and the health of the State of Illinois will indeed get worse unless the issue of how one addresses and how one deals with all of the—remember, we are the only industrialized Nation in the world, outside of South Africa, that does not have a health system, that has a fragmented system that is underfunded and does not cover everybody. So I think, in deed, the answer is: Yes, people will get worse, they will become more ill, and particularly those who are more fragile, who have no abilities and no support system will become worse, obviously.

Mr. HAYES. Is that opinion shared by all the other three?

Mr. BIRD. I would support that opinion.

Mr. ODER. I would like to make a comment on the questions of trauma. I think we need to remind ourselves that the reason we are talking about the problem of trauma network is the underfunding, the underfunding that brought about this problem, not the inability to care for the victims. The University of Chicago, Michael Reese, Weiss, did not drop out of the trauma network because they were unable to provide service professionally, they dropped out because they were unable to provide the service economically. So the underlying cause of the problem is the underfunding of the system.

Mr. BIRD. I would only like to add, I think it was brought out in some of the PROPAC commission reports that came out Friday as well as some of the testimony that was given in Washington, that is that health care continues to be the major area of cuts in order to reach budget deficit reform or Graham-Rudman reform, where about 9 percent of the budget and about 14 percent of the cuts. That is in this new proposed budget too. It is my understanding that Medicare constitutes about 10 percent of the Federal budget yet budget cuts amount to 50 percent of all nondefense budget reductions. We are taking it from the wrong source. As long as we continue to have an elderly population, and in Chicago particularly we have a rapidly growing elderly population, but we keep cutting the resources I think we are going to have a health care crisis that you are asking about, Congressman, that is that some people are going to fall through the cracks and they are not going to—they have already fallen through.

Mr. HAYES. I know my time is limited so I have to get into this a little deeper. I think you mentioned it, Ms. Rothstein. There is a growing opinion, I think, that we need some kind of national

health care program financed by the Federal Government. Now, I would like to know whether or not these four people who appeared before us are supportive of that kind of program because you know there is legislation now pending leading in this direction by my colleague out of Ohio, Ms. Oakar, and there is going to be resistance I would like to know what people in my own area feel about this kind of program. Would you support a national health care program?

Ms. ROTHSTEIN. I think that each of us sitting here probably have different opinions or maybe a different one yet the same. I think we all agree, at least I think we all agree, that we need to have a system that is quite different than the one we are currently under. And I think we all agree that health needs to be an imperative and an important issue on the national agenda whether it is an election time or it is not an election time.

I think we can all agree that every where else in the world, other than South Africa and the United States, there have been resources put into the health care system, and yes, there are problems with national health. There is no question there are problems in Great Britain and there are problems in Canada, and there are problems all over the world. But, I think we need a national health system. I think where you would have differences would be what kind of a national health system should be put into place, who should put it into place, how it should be paid for, and so on. But I think everyone agrees, including the American Medical Association, that something needs to be done.

Mrs. COLLINS. Will the gentleman yield?

Mr. HAYES. Yes.

Mrs. COLLINS. Thank you. I would like to point out that the gentleman and I have spoken to the chairman of the Health and Environment Subcommittee, Mr. Waxman, early last year about the possibility of having a hearing regarding these matters in the city of Chicago. The schedule, of course, has been very very full with the subcommittee, I mean, we had the issue of clean air, among other things, that we have been working on for well over a year and so forth and finally, because a number of things that were happening here in the city of Chicago he suggested that perhaps I would chair this particular meeting for him because he did not want to come here. So it is not a matter of election time that we are here, we have been concerned about health in the city of Chicago ever since we have been in office. I want the record to show that this has nothing to do with an election time it was just the chairman's timetable that we must abide.

Ms. ROTHSTEIN. No, I did not say that. I say that health needs to be addressed at all times.

Mrs. COLLINS. I just wanted the record to be very clear on that.

Ms. ROTHSTEIN. No, that was not a problem.

Mrs. COLLINS. I yield back to the gentleman's time.

Mr. HAYES. Your reaction, Mr. Bird, to the question.

Mr. BIRD. Well, I would agree that I think we all agree that something has to be done. I think what we need before we have a national health care system I think we need to have a national health care policy. I think that is the biggest problem that we have coming out of Washington is that we have not agreed upon what

our health care policy is—is health care truly a right? And if it is then that creates a framework and we go on to the next step.

I think the whole idea of mandated benefits has to be reexamined. We have provided mandated benefits for Workman's Compensation, for Unemployment Compensation and so forth. I think it is now time that we seriously looked at mandated benefits for employers to provide a minimum level of health care benefits to their employees. I think the time has come for that, yes.

Mr. HAYES. Mr. Hansen.

Mr. HANSEN. I do not know, Congressman Hayes. I think any step in any direction right now would be an improvement. You talk about the people that are falling between the cracks. You talk about people that do not have any access to facilities that provide care. You can interject anywhere in that sentence anywhere you want and say "Let us go with a national health care system, let us give a fantastic rate of reimbursement for people so they are not losing their shirt when they provide cares for patients that are system breakdowns instead of episodic illnesses." And I will come back and say I hope you have the people who provide the care because if you do not have the care providers all the money in the United States Treasury is not going to improve the quality of health care. It is that system.

So as Earl said, it is not just an issue of reimbursement or it is not just lacking a national health care system, it is a policy that this country has got to come to grips with that it is going to have access regardless of where you are and it is going to take steps that if the private marketplace does not provide the resources, resources meaning dollars and people, the Federal Government is going to have to deal with it. Until that is dealt with, to go back to your original opening question, I think you will begin to see some statistics begin to develop that you will not like. You will see some problems in trauma care, you will see some problems in infant mortality.

At Cook County Hospital, for example, you were talking about underweight babies, 5 years ago about one out of every four of our deliveries was a high risk delivery in our OB department because of hospital closures, because the perinatal network that we are in is basically disintegrating almost one out of every two is now a high risk.

Mr. HAYES. Our time is already up. I have got to get some reaction from Mr. Oder.

Mr. ODER. Well, there are a lot of definitions and interpretations, misinterpretations, about what national health insurance means. I cannot believe anyone would be opposed to a universal health system where everyone has access to health care. I think the funding tends to be the big controversy, and certainly we need to build on what we have. If we would take the 37 million people that are uninsured or underinsured and break those down into different groups, deal with coverage for the ones who are employed and their dependents, you cut that down into a group. Expand the maternal child health as you are trying to do, that takes out another group. I think we have to work on it piece-by-piece if we are really going to accomplish something and bring a health system to everyone.

Mr. HAYES. Well, I just I think it is correct to assume, I am trying to maybe draw together what your opinions have been that you expressed. There is a difference of opinion as to whether or not we really should have a national health care program, there seems to be that. Our only concern is, and Ms. Rothstein, I think you touched it, 300 million people in this country of ours who have inadequate health insurance or something, I do not know how you termed it. All I know is that 37 million people, according to the statistics, have no health care, that number is growing. I want to do something about it as a Congressperson.

I think we ought to get out of the bed with South Africa on this issue and become a part of some of the other civilized nations and come up with some kind of a program designed to offer health care to people to help them to live rather than to die. That is what I am concerned about, prolonging life. This is why I raised the question. I am seriously considering a national health care program. How we work it out is a different matter.

Final question is directed toward you, Mr. Robbins. You know I could not let you go without raising this question. Mr. Bird, since you have some contact with the State health care program or with the city, what is the status of getting Provident Hospital reopened, if you know? Mr. Hansen I mean. No, he is at County Hospital.

Mrs. COLLINS. Yes.

Mr. HAYES. Mr. Robbins is with the Illinois Hospital Association. Now, the governor has a hand in this pie.

Mr. BIRD. My understanding, I am with the Metropolitan Health Care Council, is that the governor has agreed to turn over the hospital to the county providing the county can open a certain number of days, I think it was 100 days to put together a plan in which to open the hospital and make it available to the citizens. I believe that study is now being done.

Mr. HAYES. Are you familiar with that, Mr. Hansen?

Mr. HANSEN. Very much so, Congressman.

Mr. HAYES. All right. Okay. Where are we?

Mr. HANSEN. We have met with the representatives of Mr. Kemp, we have met with Mrs. Jordan about 2 weeks ago, representatives from president Dunne and from Governor Thompson's office. As Mr. Bird says, the Federal Government's position is that within 100 days of the letter from Secretary Kemp to Governor Thompson offering to transfer the hospital from Federal hands to State hands we must provide the Federal Government with a certificate of need in terms of reopening the facility. We must provide the Federal Government with an operational plan and a budget and a source of funding for that operational plan to be institutionalized. And we must show what corrective actions need to be taken on the physical plant of the facility simply to open it and make it available for community use again and a budget for that.

We have basically filed a letter of intent in Springfield with the State notifying them that we will file a certificate of need so that time clock is already running so that part of the process is underway. We have walked through the facility many many times with a variety of people and their specialties such as buildings and grounds, electricians, plumbers, tradespeople, what have you. We have got an estimate as to what it will take to bring the building

up to the standards in order for it to be licensed by the State and by the city and to be opened. That figure looks to be somewhere around $17.5 million. And so the county will have to go before the board of commissioners later this year, this spring, for bonding authority to set aside the dollars for that activity. And we have started an organizational plan in terms of the services that would be available when the hospital were to open under the county's auspices.

Those documents will be in Mr. Kemp's hands within the 100 days of his original communication. I do not believe that it is their intent any longer that we have to open the doors within 100 days, it is that we simply have to have——

Mr. HAYES. Got to have a plan.

Mr. HANSEN. That is right. And then they will be able to transfer it from the Federal Government to the Governor's office. Mr. Thompson's office has already indicated that they want to be the shortest, on record, owner of the property as possible and they will transfer it to the county as quickly as they can.

Mr. HAYES. Using that age old expression, "Let's don't fiddle while Rome burns."

Mr. HANSEN. Absolutely correct.

Mrs. COLLINS. Mr. Hansen, while you are speaking, is Cook County Hospital a member of the National Association of Public Hospitals?

Mr. HANSEN. Yes, ma'am, it is.

Mrs. COLLINS. Is there some kind of concept for voluntary contributions?

Mr. HANSEN. There is a new program developing. The primary user right now is the State of Tennessee in which hospitals that have a disproportionate share of indigent care literally turn back, initially, part of their operating budgets to the State who in turn then use those dollars to increase the Medicaid match. On the first set of figures that have come back it looks like for every dollar that these hospitals contribute to this fund they actually get an increase of $3 back.

As part of my testimony, I make reference to this and suggest it to your staff that they get in touch with the Association of Public Hospital people for the sample legislation.

As it is currently being developed it is happening at the local level, it is happening at the State level, as opposed to the Federal level. If this kind of an umbrella were put into the Federal legislation it might short circuit, as Congressman Hayes says "Don't fiddle," if we get it done once it might apply to all 50 States and it might be a substantial benefit to us disproportionate share hospitals.

Mrs. COLLINS. Thank you. A final question that I have for Mr. Oder. Would you have any information as to how much, if at all, ICARE is responsible for their problems with the perinatal system?

Mr. ODER. As in all areas that are underfunded, it becomes a problem. Now, the problem that I am most familiar with in the perinatal system applies to Rush, of course because that is an area I see everyday.

The ICARE system, as you know, contracts for a certain number of days. The perinatal days are separate in the contract. When we

received a contract effective the first of September we were allocated 3,000 perinatal days. We use perinatal days, almost 6,000 days per year. At this point we are out of perinatal days, we have used our 3,000 days. We have talked with——

Mrs. COLLINS. Are you saying that already, in March, you have used your days already?

Mr. ODER. For this contract year.

Mrs. COLLINS. For this contract year, which expires when?

Mr. ODER. Which started the first of September. We have contacted the Department of Health who is responsible for the perinatal network and also contacted the Department of Public Aid to try to get more days in our contract. The Department of Public Aid said they had allocated sufficient days for the area and we should use hospitals in the area to transfer the perinatal patients. The Department of Health reminds us that that is in violation of our perinatal contract as a referral facility we are obligated to accept those babies at Presbyterian-St. Luke's whether we get paid for them or not.

We have a meeting set up later this month with the Department of Health to try to reconcile to departments of the State as to how we can continue to accept perinatal transfers.

Mrs. COLLINS. Does anybody else care to answer that question? All right, thank you very much. I do not have any more questions. I thank the panel for coming before us. Your testimony has been very enlightening.

Our next panelists are Mr. Robert Kohl the director of the Winfield Moody Health Center, Near North Health Services Corp.; Dr. Doris McCulley also at the same institution. Would you come forward please? Will Ms. Margaret Davis also come forward please. Dr. Norman is not here yet. Now, I understand that Ms. Jeanette Harris is not able to be here because she had to take her daughter to the hospital. Why do we not begin with Mr. Kohl.

Mr. KOHL. Since I am here with Dr. McCulley, I ask that she be able to go first.

Mrs. COLLINS. No problem. You may begin at this time.

STATEMENTS OF DORIS McCULLEY, MEDICAL DIRECTOR, WINFIELD MOODY HEALTH CENTER, NEAR NORTH HEALTH SERVICE CORP.; ROBERT KOHL, EXECUTIVE DIRECTOR, NEAR NORTH HEALTH SERVICES CORP.; AND MARGARET DAVIS, HEALTH CHAIRPERSON, ILLINOIS BLACK LEADERSHIP ROUNDTABLE

Ms. MCCULLEY. Good morning, Representatives Collins and Hayes .

Mrs. COLLINS. Good morning.

Ms. MCCULLEY. I am the medical director at Winfield Moody Health Center, Near North Health Service Corp. There we service the low income community of Near North, Cabrini-Green, and West Town.

Mr. HAYES. Pardon me. Could you just lower the mike and pull it in a little closer. We are having trouble hearing you, I am.

Ms. MCCULLEY. I said, I am the Medical Director of Winfield Moody Health Center which is a community health center that

services the low income communities of Near North, Cabrini-Green and West Town.

I have worked in the public health sector for my entire career of 13 years.

Mrs. COLLINS. Would you hold just a moment. We are trying to find a copy of your testimony. Did you provide the subcommittee with a copy? It is a subcommittee rule that copies of testimony be provided to the subcommittee some 4 or 5 working days before the hearing. I hope that you have been advised of that fact, the rest of those who are to testify because we cannot operate without the testimony.

Ms. MCCULLEY. That is just one copy, I am sorry.

Mrs. COLLINS. Okay. Shoot. You may proceed.

Ms. MCCULLEY. As I said, I have worked in the public health sector for my entire health care career, serving both as a provider as administrator, most recently, as the past Medical Director of Provident Hospital prior to its closing. So I am very familiar with the health status in these communities.

I would like to speak about the Medicaid and the Maternal and Child Health Care Block Grants because of the significant disparity of positive maternal child health outcomes for black, poor, and medically indigent. In 1986, nationally, infant mortality rate was 18 per 1,000 live births for nonwhite and 8.9 for white. In my service area, for the same year, it was 26.6 per 1,000 live births and in 1987 it 31.4 per 1,000 live births. Nationally the births to teens was 10.6 for white and 22.8 for nonwhite. In my service area for the same period it was 33 percent.

These statistics are striking and if you couple that with the fact that at this point we are seeing an increase in the numbers of chemical substance abuse, particularly cocaine, the—increased violent crime and child abuse and the—newborn illness and death. You are increasingly able to comprehend that these are concerns that any commission that services in these areas would be overwhelmed with. I think that this, more important than these statistics is what you do about them. The worsening statistics must be confronted not only with medical management but in paying attention to the development of—infrastructure to coordinate and address the basics of health care as well as the psychosocial needs of our clients.

We must also reduce the manpower shortage. That is, the availability of people that are interested in working in the areas of this nature, particularly medical providers in the obstetrical/gynecology area.

In 1980 the Graduate Medical Education Advisory Committee produced a report projecting a future oversupply of physicians. The committee determined that the surplus of physicians would lead to physicians voluntarily working in underserved areas. This lead to the gradual decline in the number of National Health Service Corps physicians from a high of 13,000 per year to currently less than 100. This loss has a significant impact on areas such as ours.

If you look at the fact that essentially these physicians were subsidized by the Federal Government. In my instance, if you look at the fact that a practicing obstetrician/gynecologist in a competitive

market costs about $163,200 compared to $64,000 for a National Health Service Corps obligated obstetrician/gynecologist.

Mrs. COLLINS. We are going to add an additional 2 minutes to your time because we used up part of your time.

Ms. MCCULLEY. We must also look at the needs that recur with our patients we are currently servicing because these patients have specific needs that are not necessarily met by pure medical model. There is a need for community-based identification of the clients that fail to reach out to health care centers and have an intervention early in their pregnancies. There is a need to case manage prenatal care of the high risk pregnant females, for example, the coordination of schools integrational patient education, counselors, social workers, and an opportunity to intervene and optimize the health care period during that pregnancy. There is a need to return to the concept of community-based nurse care of the public health nurse. And last, there is a need for financial ability to closely monitor the growth and development of the babies so that therapeutic intervention can occur as soon as possible after the problem is identified.

Finally, I would like to summarize, stating that the retention of manpower resources and the coordination of basic primary care with social services is frequently lost in the administration of block grants. As it now prevails, both of these issues need to be immediately addressed. Part of the solution may lie in the discontinuation of the splintering that takes place in developing new programs which take away from the primary care delivery system development in an integrated organized faction, organized aspects so that you can address the reshaping of some of these pressing needs that are equal to the medical component alone. Thank you.

Mrs. COLLINS. Thank you, Dr. McCulley. Mr. Kohl.

STATEMENT OF ROBERT KOHL

Mr. KOHL. If I may, I would like to characterize the comments of Jeanette Harris who has a priority of taking care of her 1-year-old child right now in the hospital. She had lived in Cabrini-Green for 22 years. She is 22 years old, has four children ranging from 6 to 1 year old and has been on public aid since she was 18. I would like to contrast the experience she had with our health center with that of a community-based clinic, a store-front clinic, that is associated with a public aid HMO.

She was found by one of our outreach staff working with the infant mortality reduction program when one of our staff was visiting her sister. At that time she was living in an apartment that had water running down the walls, there was sewage backing up out of all of her drains. Her children were having trouble getting their shots and she was running out of food. There were mice throughout the apartment. In these kinds of horrific conditions it is more than health care that is needed.

She came to our health center and our staff got to work on these problems. Her daughter got her shots. They helped her son get a regular doctor. She started participating in one of our parenting groups that meets weekly at our health center. She was enrolled in the WIC Program. She started to talk to the job training people

about getting a GED. And finally, is getting help with getting adequate housing. She is also disenrolling from her Medicaid HMO so that she can participate in our health center, see our doctors.

For her the HMO has been confusing and unreliable. She says that it is easy to get on but hard to get off. She characterizes it as a con job, because people tell you that you can see a doctor and get more medicine, see an eye doctor—but that is not true.

At Winfield Moody Health Center it has been much better for her compared to other neighborhood clinics. They take care of her life issues like housing, drugs, teen pregnancy, infant development, nutrition, and employment, besides of course, good health care. I think it is clear that for Jeanette Harris the answer is more than health care and improving her health status.

If I may I would like to go on to my remarks. I am Bob Kohl. I am the executive director of the Near North Health Service which operates the Winfield Moody Health Center.

Within our full service community health centers two-thirds of our clinical activity is related to mothers and children. We are provider of maternal and child health care which I will refer to as MCH, as a subcontractor of the Chicago Department of Health under the Federal MCH Block Grant Program initiated in 1982.

In fiscal year 1983 our funding level was $547,000 which dropped to $520,000 the next year where it stayed until 1990 when it increased to $578,000. In order to obtain this increase, however, we had to add a public health nurse so we essentially have been at the same level since fiscal year 1983. Meanwhile, our patient volume has increased by over 50 percent to 22,000 annual MCH visits. Also, our costs have increased dramatically during this time period, over 40 percent due to inflation alone. Also, our physician costs, as Dr. McCulley stated, have increased over 100 percent due to the demise of the National Health Service Corps and also a dramatic increase in malpractice premiums, especially for obstetricians.

Given the disparity between available funds and increasing volume of services and increasing costs we have had to seek other sources of income to maintain the integrity of our MCH Program. The mainstays we look to have been the section 330 Community Health Center Funding and the WIC Program which is short for the supplemental feeding program for women, infants and children. We have also obtained funds from the city related to the State's Infant Mortality Initiative known as "Families With a Future", although, our particular program is funded through the city's Community Development Block Grant funds.

We participate in the State's prenatal initiative called Parents Too Soon and have other funding programs in education, substance abuse treatment, parenting, infant development, home visiting, to allow us to offer a comprehensive community-based program.

As pointed out in your introductory remarks the MCH funding to the State has increased 23 percent while the city's share has only increased 2 percent. From our vantage point, it appears that the State has initiated a series of new categorical programs with the increased Federal MCH block grant funds such as the Parents Too Soon Program, the Nine by 1990 Program which subsequently was renamed the Families With a Future Program, the Pediatric Primary Care Program, among others. With the exception of the Fam-

ilies With a Future Program a limited portion of these funds flow through the Chicago Department of Health.

Many of the categorical programs actually generate additional need for prenatal care services, thus, we have got the paradox of increasing demand while Chicago's MCH capacity, through the Chicago Department of Health and its subcontractors, is being eroded due to inflation and increased costs. Meanwhile, Illinois remains one of the poorest States in infant mortality outside of the Southeastern United States. And, Chicago is among the worst large cities in the country for MCH status, especially for blacks.

There are several consequences to the MCH block grant approach: first, the allowance for splinter programs really should be coordinated at a State and local level; second, local agencies experience additional administrative costs in applying for multiple programs with essentially the same goals as the MCH block grants; and finally, local agencies which are aggressive in meeting the needs of their population have to develop sophisticated accounting and administrative procedures to provide multiple reporting systems.

I would add that while we are convening a health care summit in Chicago, in Cook County, we should take every opportunity to eliminate such fragmentation of services. This not only would effect our particular health center but it is really the prenatal system throughout Chicago. Thank you.

Mrs. COLLINS. Thank you for your testimony, Mr. Kohl. Ms. Davis.

STATEMENT OF MARGARET DAVIS

Ms. DAVIS. Good morning. My name is Margaret Davis and I am a registered nurse. I serve as the health chairperson of the Illinois Black Leadership Roundtable. This organization is the coalition of black organizations dedicated to shaping and preserving the existence and security of the black community.

Congresswoman Collins and Congressman Hayes and distinguished panel, I want to thank you for convening this congressional hearing because the State of Illinois has truly not managed its Federal money allocated for health in an effective way to meet the health needs of its citizens. To drive home this point we only have to look at the Seventh Congressional District and the First Congressional District and note that over 10 hospitals have closed and one major federally funded clinic—Health Center. The principal reason for the closings is the refusal by the State of Illinois to reasonably compensate hospitals and clinics for care provided to Medicaid patients as mandated by the board amendment 1981, attachment C.

How can the State of Illinois be the sixth richest State and be 50th in Medicaid reimbursement? The answer is: The State is balancing its budget by not paying its health providers.

The county of Cook is conducting a health care summit to revamp our entire health care delivery system, however, when we look at the major players in the process those registered nurses and African-American practicing physicians have been excluded. Since it is evident that the voices of African-Americans may not be

heard the Illinois Black Leadership Roundtable conducted an African-American health care summit. Twelve principles were developed which would improve the health status of African-Americans in the county of Cook as submitted in attachment C.

In addition, many of our coalition members testified at a public hearing. The testimonies from African-American providers and consumers were excellent. We have a compilation of these testimonies for the panel because I know that Congresswoman Collins wants to get a flavor as to what is going on in the community as it relates to health so we have 50 testimonies that we have submitted to your staff.

Upon reviewing if the State of Illinois has utilized its health care dollars as intended by Congress the Illinois Black Leadership Roundtable had the following concerns: One, Congressman Hayes, Provident Hospital. Only in the public sector would a decision be made to give an institution like Provident Hospital to Cook County Hospital. Cook County Hospital has not demonstrated expertise in managing its existing hospital, having had numerous violations cited by HICVA. County Hospital's experimentation on obstetric patients demonstrated an inefficient research board. Last, Cook County Hospital's hiring practices, especially in management, is based on patronage. Given their record a private hospital would not be allowed to expand. You would not give Provident to Rush, you would not give it to Mt. Sinai if they had these types of violations.

Secretary of HUD, Jack Kemp, has asked Governor Thompson to develop a board—to oversee the transfer of Provident Hospital from HUD to the State. This process has not been shared with the public and inclusion of African-Americans into the process is questionable. We have alerted Louis Sullivan, we have also asked the Illinois Black Caucus to look into this matter. We feel that this hospital is very dear to African-Americans. It has very significant historical importance. We feel this historical importance of Provident Hospital to African-Americans is equal to the ancestral—importance to Native Americans, therefore, we want the Congressman, especially our African-American Congresspersons, to look into including us into the process.

HMO's. The Illinois Department of Public Aid cost containment measures in health care has produced a proliferation of Medicaid HMO's. We have State and Federal hearings but no substantial corrective measures have been developed.

Mile Square Health Center, our own University of Illinois Hospital has received major State dollars and its patient base has eroded, the board of trustees did not choose to bail out Mile Square Health Center. Yet, the same hospital can provide State paid pediatricians to staff, Michael Reese Hospital, a private facility.

Immunization. Our children are still dying from measles in 1990. Even today, we have not seen a plan developed by the city of Chicago or the Chicago Board of Education to provide immunizations for our children so our children will not be released from school.

Infant Mortality. Again, in our area, it is equal to Third World Nations.

AIDS. Distribution of money in AIDS services continues to be based on politics, not public health. We need competitive—cultural-

ly sensitive providers and organizations equipped to do the complex work in caring for individuals infected with HIV.

Trauma care. Hospitals have left the trauma network primarily because of reimbursement. However, some trauma centers left because of the influx of trauma cases interfered with their scheduled elective surgeries. These hospitals are recipients of Hill Burton dollars.

Long term care. Illinois has the worst Medicaid reimbursement rates for nursing homes in the Nation yet it has one of the most stringent regulation policies.

So please, again, try to include many of our African-American consumers and providers in this process because we are dying disproportionately. The hospitals that close, close in our areas and we are not even included in the process of making decisions. Thank you.

Mrs. COLLINS. Mr. Kohl or Dr. McCulley, how does the infant mortality rate in your service area compare to that of the rest of the city? Either of you.

Ms. MCCULLEY. I think that you have to pretty much go census by census. As you may be aware, in terms of our service area, it is one confined population there that if you included that whole geographic community you would not have those statistics. If you were to go to the west side or to Humboldt Park or Southside Grand Boulevard, Fulton area, you have comparable statistics. It is based primarily or related primarily to the patient population.

Mrs. COLLINS. So have you done anything to get an analysis of that situation from those general areas that they represent?

Ms. MCCULLEY. Well, those statistics are compiled by the city.

Mr. KOHL. Can I just characterize those? For a 3 year rate we have 31.4 as our infant mortality rate in our target area compared to the city it is more like between 15 and 16 deaths per 1,000 live births. So we are about double for city average.

Ms. MCCULLEY. And that is true of those other three areas that I was pointing out.

Mrs. COLLINS. So what do you attribute, Mr. Kohl, that disparity?

Mr. KOHL. Well, I think it is certainly the concentration of poverty. The Cabrini-Green area is the second largest concentration of poverty within the United States. And all the attendant problems that go with that ranging from the poor housing conditions to the fearful environment, the isolation that exists in an environment filled with fear, with gangs, with drugs, those have been significant factors. I would say, first of all, the poverty and the environment and second of all, the drugs, in particular, have started to have a severe impact on the health status of our infants, especially in the last 3 years we have seen that the statistics have gotten much worse. We attribute that latest worsening to the drug problem.

Mrs. COLLINS. The State as a whole got an increase of 23 percent for maternal and child health under the Block Grant Program and it is my understanding that only about 6 percent of that has actually floated to the Chicago service area. The—increased by 6 percent. How would you have used funds differently had the entire 23 percent increase been made a part of your budget if it had come to you directly? Either of you, you or Mr. Kohl.

Ms. McCulley. If the entire 23 percent had come to our budget we would have been able to better integrate the services that I have indicated needing to be integrated. The other thing that I think we would have expanded earlier into the situation regarding drugs and cocaine babies in our area, I think that had we started a year earlier perhaps we would have had much more of a significant impact.

Because of the drug situation I think that programs surrounding that such as grandparent support or support for those individuals, significant others, for those individuals who will take on the care of these infants that are born addicted and frequently their parents are addicted and do not have the basic care nor the additional support care needed for a child that is addicted.

The other areas that I think we consider of high significance would be the followup of our patients that have sickle cell disease or hemoglobin—disease which effect pretty much all of our patient population.

Mr. Kohl. I would just like to add that we have heard about hospitals closing today but when the prenatal care infrastructure, not just our health center, but when we look at all of Chicago and all of the people that get prenatal care and the fact that Chicago is the worst in black infant mortality almost among all the large cities we have to start looking at answers that are going to improve that situation. One of them is to invest in the infrastructure of prenatal care throughout the city. Certainly closing hospitals in high need areas does not help either but I think that looking at the prenatal care network that is one place we have to start.

Mrs. Collins. Mr. Kohl, in your written statement you mention that your costs have increased over 40 percent due to inflation then you say "Our physician costs have increased over 100 percent due to the demise of the National Health Service Corps and the dramatic increase in malpractice premiums especially for our obstetricians." Now, how do you think the Federal Government can help with the physician manpower shortage in medically underserved areas? Do you have any suggestions about that?

Mr. Kohl. Well, it certainly would help areas like the underserved areas of Chicago, even in rural areas as well, if the National Health Service Corps was intact as it was about 5 years ago. As Dr. McCulley stated, at that time there were many more physicians available. Now we have to compete with HMO's and with other health providers for those obstetricians, pediatricians, for internists, and other primary care physicians. And the salaries that we have to offer our physicians, even though there are many that are committed to community health, are much higher, independent of that, just the availability of physicians and the malpractice problem, there are several proposals before Congress that could be helpful, one has to do with the Federal Court Claims Act that could be a solution but that would indemnify physicians through the Federal system.

There are some alternatives to that that have been looked at as well because that is not the most popular solution among everyone so I think the other solution was a risk retention group that would be mandatory for all community health centers throughout the country to join. One of those solutions would be very helpful con-

sidering we spent over $25,000 per physician on malpractice costs. In a center like ours, we are spending over $100,000 on malpractice costs. We have not had a claim in our 24 year history, it is hard to see where the increased cost is producing better health care for our community.

Mrs. COLLINS. Thank you. Ms. Davis, your testimony I found to be very very interesting and I just wanted to make a comment in particular on the Mile Square Health Center. For many years I have been trying to help resolve the problems at Mile Square. Last year I successfully was able to secure the first commitment for Federal dollars since 1985. I have recently been informed that the Public Health Service is entertaining a proposal that will reopen the doors at Mile Square. Of course, we are optimistic that the doors will be open sometime this year but I wanted you to know that we have not rested and that we do not plan to rest until these doors are reopened. Mr. Hayes.

Mr. HAYES. Thank you, Madam Chairman. Ms. Davis, you refer to several attachments, I think it is five you referred to, A, B, C, D, and E. How can we obtain copies of those?

Ms. DAVIS. I gave them to the staff person.

Mr. HAYES. You gave it to them? You have one copy?

Ms. DAVIS. Yes, but I have an extra copy of those African-American testimonies for you Congressman Hayes, you have it in your office.

Mr. HAYES. I do have it in my office?

Ms. DAVIS. No, I will give it to her so you can have it in your office.

Mr. HAYES. Okay, I appreciate that very much.

Ms. DAVIS. Those testimonies, we felt that they were very creative because what has happened is that we work with the constituents that this health care summit is trying to deal with. So our consumers and professionals have prepared testimonies but we have not gotten the type of participation at the higher level. All the decisions are being made at a very high level. We do not have the type of representation from nurses and practicing African-American——

Mr. HAYES. That is true with a lot of other people, even in the Congress.

Ms. DAVIS. Right.

Mr. HAYES. When you look at the fact that we have only 24 African-Americans out of 435 in the House of the Congress and they say we represent 12 percent of the population, which is an undercount. Twelve percent of 435 would be 52, so we find ourselves very short at 24.

Ms. DAVIS. Thank you.

Mr. HAYES. I have no disagreement with the position you take in respect to greater participation on the part of African-Americans. I want to caution you against one thing, if we proceed to take the census—I just found out the other day which is important to our even getting a distribution of funds in our direction—our numbers are important to be counted. We cannot no longer, I found out, refer to ourselves as African-Americans, we have either got to be either Negro or Black to be counted in that fashion. I just want to indicate this is a problem that we must get over to the people.

Ms. DAVIS. I understand.

Mr. HAYES. The thing that disturbs me so much, to say I agree that we are underrepresented in most of those policy making levels, one must, as we proceed to look at Provident Hospital, come up with the answer of where are the funds coming from to open and keep that hospital open. Do you have any suggestions? I do not just want to get it open, I want to keep it open and run on the basis that it furnishes services to people around it.

Ms. DAVIS. Yes, Congressman Hayes, we do have some recommendations for the funding. What we believe is that with the private/public funding mix, that the community can begin to reopen Provident Hospital. We have introduced a resolution to Commissioner Rose Marie Love to have a bond floated on behalf of the community to open Provident Hospital, $30 million bond. What we are looking at is that there has been a precedent set, the Jewish Federation, Catholic Charities, Martha Washington Hospital have all received bonds through the county government to help their organizations operate. That is one thing. We are looking at purchase of service agreements. We have already noted in the testimonies that southern and northern suburbs indigent individuals cannot receive health care because many of the providers do not accept Medicaid. What we are looking at is that the county government should have purchase of service agreements in those sectors in which health care can be delivered and they do not necessarily have to open up other facilities. We are looking at that for Provident Hospital.

The patient mix would have to be different. We cannot be all things to everyone. We do go on record as saying that African-Americans are managing all these other hospitals. We can pool those individuals and run our own hospital. We have the expertise. Argument is that we cannot keep it open but I am suggesting that we should be given the same discretionary funds that other ethnic groups are receiving. We look at Presidential Towers here in Cook County, they are at a deficit of about $30 million HUD is going to give them for the discretionary fund. We want access to those things that discretionary government funds for the black community.

So, we are definitely concerned that if we receive that hospital that we must keep it open, we have to be accountable as black people in the 1990's. We are not going to have business as usual, we have to be an accountable race of people but if we want to argue health care we have to have institutions at a—level so we can be in the ballpark, if we do not we cannot even talk about it.

Mr. HAYES. All right. I share your opinions, most of it at least. I guess my reservations and problems come in the area of what comes first the chicken or the egg. I want somebody to take the responsibility, as you say, to fund that hospital, open it, and fund it, and keep it open, and take $30 million a year. I think we have got to have adequate staff. Certainly, we need African-Americans to run the hospital but God knows the bonding approach may be the correct approach, I do not know. It needs examining.

Who is going to float the bonds? What bank is going to write the bonds? These are the kinds of things that seem to me ought to be answered. We just cannot talk about it and not really move in the

direction of getting that hospital up. We have people dying being dragged all the way to Christ Hospital in a traumatic situation. I, as a Congressman, do not want to be in a position not pushing hard on this to get the same kinds of service that people deserve and need. It is not just race, it is economic. We have got some poor people who have no kind of health care and God knows I think this government, irrespective of their race, have a responsibility to do something about it and that is the area which I am pushing. Provident is a part of that, what I call a national catastrophe that exists in this country. Lord knows, to be in a position to represent a district that has 525,000 people in it and have no trauma center there or cannot get into a hospital because you do not have money—I think that is wrong. We have to do something about it.

Ms. DAVIS. Thank you.

Mr. HAYES. Thank you.

Mrs. COLLINS. Thank you. I had to step out of the room just as you were saying, Ms. Davis, about the attachments to your testimony.

Ms. DAVIS. Yes, I gave it to your staffer. It is in volumes of information.

Mrs. COLLINS. They have already been given to subcommittee staff?

Ms. DAVIS. Yes.

Mrs. COLLINS. Okay. Thank you. Now, I understand we have been joined by Dr. Barbara Norman who is the First Congressional District Health Task Force Chairman. You may give your statement. We operate, in the House of Representatives, on a 5 minute rule, that is that you have 5 minutes to summarize your statement or say whatever you want to say with the knowledge that your entire statement will be made a part of the official record. You may begin now.

STATEMENT OF BARBARA NORMAN, CHAIRMAN, FIRST CONGRESSIONAL DISTRICT HEALTH TASK FORCE

Ms. NORMAN. Thank you very much. Good afternoon.

Mrs. COLLINS. Do we have a copy of your statement up here?

Ms. NORMAN. Yes, I submitted a copy to the Congressman and I believe sent an additional copy to you.

Mrs. COLLINS. I do not have it. Hold on a minute while we get a copy. Thank you. All right, we are ready to roll.

Ms. NORMAN. Just let me know when I am close to that 30 seconds—remarks.

Mrs. COLLINS. I will go like this.

Ms. NORMAN. Great, great. I serve as the chairperson for Congressman Charles Hayes, First Congressional District Health Task Force. I am honored to have this opportunity to present before this distinguished panel, testimony on Medicaid and Maternal and Child Health Block Grants: Congressional Intent and Illinois State Policy.

The purpose of my remarks is to describe some of the social demographic characteristics of the First Congressional District and identify some of the major gaps that exist between the Federal Government intent for financing adequate health care to the medi-

cally indigent and the barriers that exist in the State, county, and city government that prevent the equitable delivery of adequate health and medical services to the poor.

The First District Health Task Force has been meeting regularly for the past 6 years to address medical, social, and health concerns of the residents. Based on the 1980 census there are nearly 580,000 residents in the district in which 90 percent are black, 3.6 percent are white, and a small percentage of Indians, Asians, and Hispanics. The largest age group in the area is between the ages of 19 and 64 which comprise 57 percent of the population where 24.7 percent between the ages of 5 to 18 years. Newborn infants and children under 5 years constitute 8 percent. Our senior citizens 65 years of age and older represent 11 percent of the population.

In 1988 the unemployment rate in our area was about 7.1 percent and the per capita income was nearly $5,699 annually. With 45 percent of the—in our community—head household and 30 percent below poverty level. It was estimated that more than 40 percent of our residents are medically indigent and eligible for the Medicaid Program.

The First Congressional District has one of the highest infant mortality rates in the State. In 1987 the Illinois Department of Public Health vital records revealed that the top three communities in the city with the highest infant mortality rate are located in the district, they are—with 32.1 infant deaths per 1,000 live births; Grand Boulevard having 30.6 infant deaths; and Englewood with 28.6 infant deaths per 1,000 live births. That means that 91.3 black infants die in our community before they ever reach the first year of life. This is tragic when compared to the national average of 9 infant deaths in black communities for every 1,000 live births in this country.

In addition, the district has one of the highest incidents in practically mortality indicator recorded. For example, cancer, cardiovascular disease, heart, lung, throat, diabetes, renal disorders, kidney failure, teen—pregnancies. Recent trends all suggest that there is a disproportionate number of AIDS cases, a resurgence of tuberculosis, and increase in the use and abuse of alcohol and substance abuse in our area, including an increase in mental illness, homicide and suicide.

I could go on and on and on but we all know the statistics by now and they are staggering. I could also discuss the association between—education, employment, economics, and transportation, associated with the high incident of personal mental and physical illnesses that ultimately ends—for all too many of our residents. Notwithstanding the mortality and morbidity or our residents it is further compounded with the closure of hospitals of which many are located in communities with the greatest need. For example, in less than 2 weeks from today Central Community Hospital will be the 14th hospital that closed in the city of Chicago within the last 5 years. It is estimated a minimum of 12 additional hospitals are destined to close in the very near future.

The issue in hospital closure and the termination of vital trauma services in our communities creates a serious question about the State and Federal Government's true intent in determining who shall live and who shall die. This can best be illustrated by the cur-

rent crisis with Provident Hospital. Located in the community area with it's boundaries of the First Congressional District, the hospital was built less than 5 years ago, operated for about 2 years, and has now been closed for more than 2½ years because of financial constraints. While closed, the United States Department of Health and Urban Development has spent nearly $85,000 a month to retain the closed facility. If—are providing financial support to operate and maintain a hospital prior to its closing rather than invest in financing to a closed institution when there has been clearly demonstrated true intent of the State and Federal Government.

Mrs. COLLINS. The time of the gentlewoman has expired.

Ms. NORMAN. May I give my closing statement on the last page? Our Medicaid, Medicare, Maternal and Child Health has already been discussed, I would just like to say that one of these—the history of health care and the lack of health care in Chicago has been widely documented and it is statistically associated with a direct relationship between race and poverty. This is especially evident in Illinois, which ranks 50th in the Nation with the ranking Medicaid reimbursements—has existed—current—State, county, city levels of government.

It is recommended that in light of the most unusual paradoxical political situations that currently exist in the State of Illinois the task force only recommends that it is imperative that the Federal Government take into immediate action in the Governor's office and the office of the president of Cook County—major changes in the restructuring of the health care facilities and in the distribution of dollars to providing health care to the medically indigent until a thorough investigation is conducted in the Office of Finance and Budget and audited.

In light of the fact that the Governor, who is a governor for 16 years, is not seeking reelection the president of the Cook County board who has been in the policy decisionmaking for 27 years and has witnessed the change of 5-year-old leadership in less than—the task force further recommends recognizing the congressional district rely heavily on financial support from the Federal Government to providing health services to its residents and given that the district holds the distinguishable feature of the highest infant mortality and morbidity rates in the district it is recommended that the government intervene and initiate immediately to assure Congressional intent—State policy for Medicaid and Medicare Child Health Block Grants. Thank you.

Mrs. COLLINS. Mr. Hayes.

Mr. HAYES. Thank you, Madam Chairwoman. I do not have any particular questions to ask the doctor. I want you to understand that your statement in its entirety will be made a part of the record of this hearing so anything you might have missed will go into the record. I want to commend you for taking the time out of your schedule to appear before this committee. I think your statement is one that is very comprehensive and it deals with a lot of facets and problems we are dealing with.

And I hope that the people who have the power to do something about this situation view the content of this hearing, they will take at least some of the testimony which has been presented to us as, one, being serious, and establish the priorities which will begin to

focus some attention in the direction of health care and the delivery of health care to people who need it very badly, particularly those who are indigent. Quite unlikely many of them will never get up in a Stealth Bomber but they are going to live here on this earth. We may have to change our priorities as to how we spend money. In order to do it I think health care is certainly one direction we ought to be turning our attention to. You all have added testimony here and I hope that they look at it and really be moved by it. Thank you very much.

Ms. NORMAN. Thank you, Congressman. It has been an honor for the me, for the task force, to present this information and we shall be looking for a response to the testimony that has been presented.

Mrs. COLLINS. We have been joined by the Congressman from the Second Congressional District, the Honorable Gus Savage who has joined our hearing. And we are going to call upon him for an opening statement shortly but in the meantime let me point out that all of your testimonies have been made a part of the record. We appreciate your coming before us and this panel is now excused.

Our next panel will be from the State of Illinois Department of Public Aid who is represented by Marlene Mulhau and the Illinois Department of Public Health by Dr. Steve Saunders. Will you come forward please?

Before we hear from the State of Illinois we will have an opening statement from the Second Congressional District, Congressman Savage.

STATEMENT OF HON. GUS SAVAGE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Mr. SAVAGE. Let me first apologize for being late but in light of the date and the time which we are holding this hearing that we are all quite busy with a lot of other appointments. But I am here and want to commend my good senior colleague, Congresswoman Cardiss Collins for her sensitivity and concern regarding what is indeed a very crucial issue and an issue which is not receiving sufficient concern or proper responses, in my estimation, by our national administration, particularly with regard to the problem of reducing payments to the hospitals for Medicaid and Medicare as proposed by the President.

It is, in my estimation, a disgrace when we should have a peace dividend because our major potential military threat from the Warsaw Pact nations is being dissolved and the economic disaster and political changes underway in that part of the world. Yet, and despite that, the President in his concurrent budget proposal has proposed increasing expenditures in preparation for war rather than to reduce those expenditures and provide better health care for our Nation. While, on one hand, he expresses such concern about drug abuse and the rising crime rate, on the other, he proposes to reduce student loans as well as Medicare and Medicaid payments. Well, one of the things that contributes most to drug abuse and crime is a lack of educational opportunities and even poor health. So that he proposes doing just the opposite of what needs to be done.

This problem is exacerbated, in my estimation, by the repeal of catastrophic health care last year. I think that was also an error. People were deliberately confused and while it is wrong and would be wrong to tax seniors or those retirees for the long term medical care a precedent that should not have been kept because you do not charge the seniors only for Social Security you charge those who are most able to pay who will then later in life become recipients, the same should have been true with regard to Medicare.

So while there was a need to change the funding of long term Medicare so that it would not have fallen as a surtax on those least able to pay, our seniors, yet it was not right to throw out the baby with the bath water. The program was needed indeed and should have been kept while changing the funding. I think that when hearings such as this are held where we receive the input of the more concerned and knowledgeable persons such as the witnesses here today that it is very helpful in building an understanding in this Nation that will be sufficient enough for us to change its neglect of the health needs of our population and the responsibility of the Federal Government regarding that. So, let me thank you very much, Madam Chairwoman.

Mrs. COLLINS. Thank you. Why do we not begin with you, Ms. Mulhau.

STATEMENTS OF MARLENE MULHAU, ILLINOIS DEPARTMENT OF PUBLIC AID; AND STEVE SAUNDERS, CHIEF, DIVISION OF FAMILY HEALTH SERVICES, ILLINOIS DEPARTMENT OF PUBLIC HEALTH

Ms. MULHAU. Thank you, Congresswoman Collins. I am here today on behalf of the Department of Public Aid and am here specifically to talk to you about the initiatives that we in the State have undertaken with respect to maternal and child health care.

In the past year to 18 months we have been fortunate in Illinois to be able to step up some of our initiatives with respect to maternal and child health and I would like to just delineate those for you.

Right now we are in the process of implementing the Presumptive Eligibility Program for pregnant women throughout the State of Illinois. We have had that program as a demonstration project in two sites in Chicago as well as one down State site and anticipate having that program statewide by the end of the State's fiscal year in June.

In addition to the medical side of the Presumptive Eligibility it also assists in linking the prospective clients to other programs which we sponsor in Illinois such as the Food Stamp Program and cash grants and is designed to get prenatal care to pregnant women much earlier and hopefully to facilitate more successful births.

Another initiative that we have in Illinois that we have in conjunction with both Department of Public Health and Department of Alcoholism and Substance Abuse is our Drug-Free Families With a Future services. This program embraces both case management and outreach and our Medicaid reimbursable services.

The funding for the local Drug-Free Families With a Future providers began in February of this year and is designed to assure treatment and services and followup care for substance abusing pregnant women, substance abusing parenting women, and newborns who have been exposed to drugs and alcohol abuse.

The other thing that we have been able to do in Illinois, and this was certainly in conjunction with the efforts of the Illinois General Assembly, has been to increase the rates that we pay to a variety of our health care providers. We were able to increase rates to physicians from an average of about $13 per visit to $18 per visit effective September first. Additionally, we have been able to increase the payment to physicians for healthy kids checkups from $21 to $30 and have had the financial ability to pay for a second healthy kids visit at the rate of $30 for that visit as well.

The other thing that we did specifically for physicians providing obstetrical services was to increase the delivery rate that we were paying for those services and also allow the physicians to bill us for prenatal visits as they were providing those visits, thus hopefully encouraging the provider to see pregnant women earlier in the pregnancy because they would be able to be paid on an as-you-saw-the-patient basis.

Another thing that we put some effort into in the last year is to designate specific public aid staff whose purpose is really to help facilitate a lot of the programs that we have with respect to maternal and child health initiatives in Illinois. These people are located in our county offices, in the local offices here in Chicago, and we have hired some field staff to work with the community medical providers to encourage them to participate more fully in the Medicaid Program.

Mrs. COLLINS. Dr. Saunders.

STATEMENT OF STEVE SAUNDERS

Mr. SAUNDERS. Thank you, Madam Chairwoman, Representatives Hayes and Savage. I would like to introduce myself. I am Dr. Saunders and I am the chief of the division of family health services with the Illinois Department of Health. Dr. Turnock sends his regrets but he could not come today as you requested.

I have been asked today to briefly discuss the MCH Programs in Illinois and their relationship to Medicaid. The format of my presentation will be to briefly introduce that topic, list some of the MCH Programs, and then conclude with a brief description of some of the coordination efforts that I think you have heard a part of already and I can elaborate a little bit more on.

We would all agree that infant mortality and childhood morbidity is a national disgrace. Our ranking as 20th amongst the rest of the nations in the world is nothing to be proud about. We clearly recognize that at the Department of Health.

The Infant Mortality Reduction Commission pointed out that there are two major strategies to reducing the mortality which are equally relevant to childhood morbidity and mortality. Those were: the increased access to health care and to make health and wellbeing of our children a national priority. I think the Health and the Environment Subcommittee should be congratulated for its efforts

over the last several years to accomplish this goal and for increasing awareness to this problem here today.

A major goal of the Department of Public Health is to reduce infant mortality and childhood morbidity. We have a number of programs funded by both title V resources, which is being characterized today as the MCH Block Grant, and State resources to achieve this goal. We not only fund programs to finance health care but we also fund programs to develop systems of care, to coordinate care for high risk populations, to develop community-based programs where they are most appropriate where they can reach closest to the community, to improve the quality of health care programs statewide and to focus on prevention and interagency collaboration and coordination.

We have in the Maternal and Child Health budget in the department approximately $60 million which is not inclusive of the budget for WIC or the budget for Communicable Disease. Approximately 48 percent of this $60 million goes to the city of Chicago, clearly a high risk area. Also, I should point out that the $18 million title V block grant is a part of the $60 million as well.

Let me briefly list some of these major programs. The first one that you have already heard alluded to today is the Families With a Future Program. This is a program funded by $11 million, a combination of title V and State resources whose goal is to reduce infant mortality.

We have infant mortality reduction programs in 20 communities statewide, these are the highest risk communities based on a needs assessment that was conducted a number of years ago. In fact, of that $11 million, $6 million comes to the city of Chicago and approximately $2.9 million is in District Seven within the city. This program is based to reduce the infant mortality, to coordinate services, and to arrange a wide array of services, both health and social services that this population needs. I think you have heard that described today quite well.

The second program I would like to highlight is the Parents Too Soon Program. This is, once again, an interagency collaborative program involving public aid and DCFS and Public Health. Our contribution is $2.5 million. The objective of this program is to prevent adolescent pregnancy and also to support pregnant and parenting adolescents, to improve the outcomes of pregnancy, and to assist parenting adolescents to get their GED, to get an education and to become a part of the workforce eventually.

Another program I would like to highlight is the Prenatal Care Program. This is a $3.6 million program. We currently have this program in virtually every county in the State. There are only three out of the hundred and some counties that did not have a prenatal care program. In this program we provide basic prenatal care and case management services to low income women. We actually paid for the prenatal care for women who could not get on Medicaid and then Medicaid for the ones that are on Medicaid. We also paid for the case management for others.

We have a new Pediatric Primary Care Program to provide pediatric primary care to low income children who are not eligible for Medicaid.

I think I will skip over some of the other programs, they are in the written testimony. I should point out that we also put $6.5 million into the Chicago Department of Health in the form of a block grant and they actually provide the children's health services in seven sites, one of which you heard about today, the Winfield Moody Health Center.

Additionally, I would like to highlight a new program that I think Maureen mentioned which is the Drug-Free Families for the Future initiative in which the State has put $2 million into that program.

Let me conclude then by just mentioning two other things that I think are relevant to this committee if you would allow me that. That is we are working with the Department of Public Aid to develop a case management program to take advantage of some of the congressional options that have been offered to us and we will be expanding out case management capabilities by about $6.5 million—cooperation with Public Aid.

And finally, we will be instituting an outreach encasement, an outreach program utilizing a hot line as recommended in the current—legislation and also a media campaign to encourage women to seek early and continuous prenatal care. Thank you.

Mrs. COLLINS. Thank you. Let me acknowledge the presence at our hearing today of Judge Abraham Lincoln Marovitz who has come in to be with us. We certainly are happy to see you Judge Marovitz and certainly wish you the best of health and happiness. For those of you who do not know, he is one of the most renowned judges, not only in the city of Chicago, but throughout this Nation. It is a really honor that he would come and observe our hearing today. Thank you.

Dr. Saunders, in 1979 the U.S. Surgeon General established goals in the area of infant mortality. One of those goals was that by 1990, which is right now, infant mortality should be no more than 9 deaths per 100,000 live births and that no racial or ethnic subgroup should have a rate that exceeds 12. The most recent figures that I have seen indicate that the infant mortality rate in Illinois was 11.6, for black babies born in Chicago the rate was somewhere around 22.9. Clearly, our babies our dying. At the Federal level we have taken note of the problem and expanded programs and increased funding but the progress seems to have stopped in Springfield. Now, how do you explain the lack of increased MCH funding in Chicago in light of the infant mortality rate that we have here?

Mr. SAUNDERS. Your figures regarding the infant mortality rate are quite correct, Illinois will not meet the Nine by 1990 objective. However, the State has put significant resources into infant mortality reduction. The Families With a Future Program which was initiated, I believe, in 1985, is currently an $11 million program which was not in existence in 1980. The only and sole purpose of that program is to reduce infant mortality.

In fact, we have seen an increase in resources to Chicago. The allocations for the Chicago Department of Health 4 years ago was some $9.5 million, this year it is $15 million. So there have been increases into the city of Chicago.

Mrs. COLLINS. Well, you mention increases into the city of Chicago, by what formula did you provide the increases to the city of

Chicago? Is it based in any kind of way on the high number of infant mortality here as opposed to something else or what?

Mr. SAUNDERS. Well, we depends on which program you are speaking of.

Mrs. COLLINS. MCH.

Mr. SAUNDERS. For the MCH Program that the city of Chicago gets is based on a prior formula. They receive, as I mentioned, about a $6 million block grant. In fact, the city is the only Health Department that receives a block grant from the Department of Health for Maternal and Child Health services.

Mrs. COLLINS. Are you doing anything to change the disparity in the funds allocation and further, what plans do you have to reduce this high infant mortality rate in the city?

Mr. SAUNDERS. Well, we are involved in a number of initiatives to reduce infant mortality in the city. The one I mentioned in the closing part to my comments was it will be increasing the amount of money for case management and coordination outreach. In the State the total increase will be around $6.5 million. We will have that opportunity because of the allowability of Federal financial participation in Medicaid Program. Approximately half of that will come into the city of Chicago, so right there it will be some $3 million that will be new resources into the city.

Also, this year we have put in an additional resources into the city of Chicago to address the issue of drug exposed pregnant women and infants as mentioned by Ms. Mulhau and in my testimony. Further, we have put additional money into the city for prenatal care outside of the MCH block grant.

Mrs. COLLINS. Ms. Mulhau, last year, I believe it was last year, the Illinois Department of Public Aid spent an average in hospitals on the west side, in my district, of $350 a day but my understanding of the average reimbursement rate of the hospital bordering the west side study group was $532 a day. How do you account for the disparity?

Ms. MULHAU. That is not a question that we are prepared to answer today but in our written testimony that we have stated we will provide you I will be happy to attempt to answer that question. The only thing I can offer, as you know, throughout Illinois all of our rates are negotiated with the hospitals who choose to participate so some of that difference would certainly be attributable to what has happened during the course of negotiations with those hospitals.

Mrs. COLLINS. Now, did you say that was in your written statement?

Ms. MULHAU. I can include an answer to that question.

Mrs. COLLINS. All right. Let me tell you this, that we would like that question answered within 5 working days and received by our subcommittee within 5 working days. That will be very beneficial to us.

And, let me ask you another question. I believe you were sitting there when Mr. Oder of Presbyterian-St. Luke Hospital mentioned that at Rush they had already used up all of the perinatal care days for the entire fiscal year and here it is just the beginning of March and they will not get any more funding, based on what has already been agreed to, until September. Now, what is going to be

done in a case like that? Will they resubmit it? Will they be given more days?

Ms. MULHAU. I think Mr. Oder mentioned during his testimony that Rush and Department of Public Health as well as the Department of Public Aid is going to sit down this month to try to work out that problem. I believe when we negotiated the city of Chicago hospitals we did feel that there were sufficient number of days citywide to deal with the perinatal health care. If Rush has run out of days then that is something that we will try to work out for Rush.

Mrs. COLLINS. How did you come to the conclusion that their days, the number of days, I believe he said something like 3,000 days, would be a sufficient amount? Is it based on some kind of formula?

Ms. MULHAU. I indicated that we were looking at the number of perinatal days citywide. I believe Mr. Oder had mentioned in his testimony that one of the things that we had suggested that Rush do is transfer some of their perinatal patients to other hospitals. Again, we were looking at the number of days citywide that were available for perinatal care. As to how Rush specifically ran out I cannot answer that.

Mrs. COLLINS. Well, I guess they ran out because there is more need for perinatal care. Mr. Hayes.

Mr. HAYES. Just one question. Hospitals throughout my district, those that remain and those that have already been closed, have one almost universal complaint, aside from the fact that inadequate amount of money is being given to hospitals to help keep them open and supply service to patients, the delay in payment is one of the things that they complain about, it just throws their whole budgetary arrangement out of line, they cannot operate without money, yet most of the Federal dollars that come in here for health care go through the State. Now, what is the reason for the delay in those funds? Can either one of you answer that question? To operate a hospital you have to have money and when somebody is holding it up it just makes it virtually impossible. Some of them have gone under because of this.

Ms. MULHAU. Congressman, the delays——

Mr. HAYES. They have no trouble getting our lotto dollars to the State, you know.

Ms. MULHAU. And I think you used a good example of the different there. The Federal money that we receive for health care is based on the State of Illinois spending that money first. We must come up with the State dollars first.

Mr. HAYES. Matching dollars.

Ms. MULHAU. Right. Before we get the reimbursement and the reimbursement is several months down the road so it is not as though we——

Mr. HAYES. Is there anyway we can speed up that procedure?

Ms. MULHAU. Based on how the Federal Government reimburses the State of Illinois for the dollars that we have spent, as I understand the process, it is probably 4 to 6 months after we spend a dollar in Illinois that we get the 50 cents back on that dollar. As to how to speed up that side of the mechanism I do not know. In Illinois we are obligated to pay our bills within 60 days or suffer a financial penalty for doing otherwise and we are working well

under that 60 day time frame which the State legislature has set up for us.

Mr. HAYES. I have talked to some of our Federal officials who have a direct relationship with this whole program. They have indicated to me that they are not the sole source of the problem, that Illinois does drag its feet in the remittance of these funds. It is hurting people who need to be helped when these hospitals close and the clinics and things like that that depend on Federal funds when they have to go through the State and they want to match it, it takes so long to do it people die while this happens. I yield my time.

Mr. COLLINS. The gentleman yields to Mr. Savage. And Mr. Savage, understand that you will get your full 5 minutes as well.

Mr. SAVAGE. Madam Chairman, I only have one question and it returns to Dr. Saunders. Again, the ratio of how funds are allocated to Chicago and the rest of the State, you talked about 48 to 50 percent. In light of the figures that were cited by the Chair in terms of how much worse is the infant mortality problem in Chicago, do you consider that present ratio is fair?

Mr. SAUNDERS. Congressman, the ratio is currently, or the allocation is based on a number of factors, one of which is infant mortality, one of which is the number of low income families in the area and a couple of others. By doing so we then rank the State and try to allocate resources to the most needy of those areas in the State that had the highest end of year infant mortality and so on. So I think that part is a fair process.

Mr. SAVAGE. No, no, no. I am not talking about the process. I am talking about the results.

Mr. SAUNDERS. The results.

Mr. SAVAGE. Yes. I am talking about if your recognition, I presume, of the problem being greater in the Chicago area, certainly you have a high concentration of employment in the Chicago area and your ratio is roughly 48 to 50 percent you said, now, do you consider that that is fair and when you consider the ratio of the intensity of the problem?

Mr. SAUNDERS. Something about 38 percent or so of the births are in Chicago and about 48 percent of the resources——

Mr. SAVAGE. No, you went too fast, what did you say?

Mr. SAUNDERS. I said about 38 or so percent of the births are in the city of Chicago whereas they get about 48 percent of the resources so we have over allocated the resources.

Mr. SAVAGE. When you say "overallocate" you mean Chicago is getting even more than you think it should get. Is that what you are saying?

Mr. SAUNDERS. No, I say they are getting more than the number of births would represent. Now, the question is whether that is fair, I think it is fair based that it is more——

Mr. SAVAGE. I yield to the Chair.

Mrs. COLLINS. I wonder about the validity of that statement because if we are running out of money it seems that we are not getting more than the number of births. Maybe you need to explain that a little more fully.

Mr. SAUNDERS. What I was trying to say is that the number of births in the city of Chicago is somewhere around 35 or so percent

of the total State births, however, in terms of the amount of money going from the Department of Health for maternal and child health into the city of Chicago it is about 48 percent of all of our budget.

Mrs. COLLINS. But is not the number of infants that are dying rather than those who are born?

Mr. SAUNDERS. That is a factor.

Mr. SAVAGE. That is a main factor.

Mrs. COLLINS. That is the main factor.

Mr. SAUNDERS. That is a very important factor and that is why we have allocated the city of Chicago in excess in the amount as would be indicated by the number of births. I was just using that as a bench mark so you could compare——

Mr. SAVAGE. Why would you not use the deaths rather than the births as the bench mark?

Mr. SAUNDERS. Well, if you look at the number of deaths I think you will find that approximately half of the deaths in the State are in the city of Chicago and approximately 48 percent of the money is in the city.

Mrs. COLLINS. No. The State rate is 11.-something percent of deaths and in Chicago it is 22.9 percent that die. How do you justify that?

Mr. SAUNDERS. How do I explain that differential?

Mrs. COLLINS. Yes.

Mr. SAUNDERS. Well, I think it has been indicated by one of the prior speakers that it has to do with the concentration of poverty and other facts, and lack of access to health care, is why there is a difference.

Mrs. COLLINS. So then you need more money. Ask your question.

Mr. SAVAGE. I would ask it, but I do not feel that the answers are responsive to the question. I have asked it several different ways. Do you insist that half the deaths are outside Chicago in the State of Illinois?

Mr. SAUNDERS. Approximately half of the infant deaths——

Mr. SAVAGE. That is what I mean.

Mr. SAUNDERS. Yes, approximately half in the total number of the infant deaths in this State are outside the city of Chicago and approximately one half are within the city.

Mr. SAVAGE. And also the same with regard to the poverty factor?

Mr. SAUNDERS. I do not have the—to answer that question. I could find out.

Mr. SAVAGE. Yeah, but you know if this is a factor in justifying the ratio, would we not need to know that?

Mr. SAUNDERS. Mr. Congressman, we have that information at the office, I do not have it right with me is what I was trying to say. Yes, it was in the formula. And, in fact, approximately $6 million of the $11 million going directly to infant mortality reeducation does go to the city, so that is in fact where we are at.

Mr. SAVAGE. And you are personally satisfied that this ratio is fair?

Mr. SAUNDERS. $6 out of $11 million, I think is——

Mr. SAVAGE. No, not the $6 out of $11 million, the whole program.

Mr. SAUNDERS. I think it is fair.

Mr. SAVAGE. The 48 percent?

Mr. SAUNDERS. Yes.

Mr. SAVAGE. The result is not working too fairly, is it? When the ratio is twice as high here, obviously the results are not coming out fairly, right?

Mr. SAUNDERS. There are clearly many problems with——

Mr. SAVAGE. I beg your pardon.

Mr. SAUNDERS. There are clearly many problems with infant mortality in the city of Chicago, and we need to address that.

Mr. SAVAGE. Thank you.

Mr. HAYES. Do you have any statistics or figures that will give us an accurate picture on the disbursement of the Federal dollars that come in? For example, how much goes for administrative costs, and how much goes for the programs which are supposed to be funded and financed by both the State and the Federal Government?

Mr. SAUNDERS. Mr. Congressman, certainly such figures are available, I do not have them with me today.

Mr. HAYES. Could you please get those and submit them to us please?

Mrs. COLLINS. In 5 working days or less. No further questions?

Mr. HAYES. No, I have no further questions.

Mrs. COLLINS. I have no further questions. We thank all of the witnesses for appearing before us. We particularly thank Congressman Henry Waxman, who is the chairman of the Health and the Environment Subcommittee, for providing this opportunity for us to have this hearing in Chicago. This hearing is now adjourned.

[Whereupon, at 12 noon, the subcommittee was adjourned.]

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